SDM

The Structured Decision Making® System

Policy and Procedures Manual

SDM 3.0

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California Department of Social Services

NCCD Children's Research Center

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The Children's Research Center is a nonprofit social research organization and
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CALIFORNIA
STRUCTURED DECISION MAKING® MODEL GOALS

Overall Goals

1. Safety
2. Permanency
3. Well-being

System Goals

1. Reduce the rate of subsequent abuse/neglect referrals and substantiations.
2. Reduce the severity of subsequent abuse/neglect complaints and allegations.
3. Reduce the rate of foster care placement.
4. Reduce the length of stay for children in foster care.

Process Goals

1. Improve assessments of family situations to better ascertain the protection needs of children.

2. Increase consistency and accuracy in case assessment and case management among child abuse/neglect staff within a county and among counties.

3. Increase the efficiency of child protection operations by making the best use of available resources.

4. Provide management with needed data for program administration, planning, evaluation, and budgeting.

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CALIFORNIA
SDM® ASSESSMENT DEFINITIONS

1. Caregiver: An adult, parent, or guardian in the household who provides care and supervision for the child.

Circumstance	Primary Caregiver	Secondary Caregiver
Two legal parents living together	The parent who provides the most child care. May be 51% of care. 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.	The other legal parent
Single parent, no other adult in household	The only parent	None
Single parent and any other adult living in household	The only legal parent	Another adult in the household who contributes the most to care of the child. If none of the other adults contribute to child care, there is no secondary caregiver.

2. Family: Parents, adults fulfilling the parental role, guardians, children, and others related by ancestry, adoption, or marriage; or as defined by the family itself.

3. Household: 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. This may include persons who have an intimate relationship with a parent in the household (boyfriend or girlfriend) but may not physically live in the home or a relative where the legal parent allows the relative authority in parenting and child caregiving decisions.

   WHICH HOUSEHOLD IS ASSESSED? Structured Decision Making® (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 of the alleged perpetrator. 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.

   Conditionally:

   - If the alleged perpetrator is a non-custodial parent, also assess the custodial parent *if there is an allegation of failure to protect*.

   - If a child is being removed from a custodial parent, *also assess any non-custodial parent identified* if he/she will receive child welfare services.

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CALIFORNIA
SDM® OVERVIEW

See policy and procedures sections for each tool for complete details.

Decision	SDM® Tool		Which Cases	Who	When
Accept referral for in-person response?	Hotline Tools	Screening tool	All referrals created in CWS/CMS	Worker receiving referral	Immediately
How quickly to respond?	Hotline Tools	Response priority	All referrals assigned an in-person response	Worker receiving referral	Immediately
Path of response*	Hotline Tools	Path decision tool—evaluate out	All referrals that are evaluated out	Worker receiving referral OR designated differential response worker	Within five days
Path of response*	Hotline Tools	Path decision tool—in-person response	All referrals assigned an in-person response	Worker receiving referral OR designated differential response worker	Immediately, if response priority = 24 hours; within 24 hours if response priority = 10 days
Can the child remain safely at home?	Safety assessment**		All in-person responses	Assigned worker	ALWAYS: prior to completing first face-to-face (record within 48 hours). Additional requirements: see pages 49–50
Should an ongoing case be opened? At what service level?	Risk assessment		RECOMMENDED: all in-person responses. REQUIRED: all substantiated and inconclusive in-person responses.	Assigned worker	Within 30 calendar days of first face-to-face contact
Focus of case plan	Family strengths and needs assessment		All open cases	Worker responsible for case plan	Initial: Prior to initial case plan Review: voluntary, within 30 days prior to case plan; court, within 65 days prior to case plan
Can child be returned home, or should reunification efforts continue, or should permanency goal be changed?	Reunification reassessment		Cases with at least one child in out-of-home care with goal of return home	Assigned worker	Division 31 = review every six months. No more than 65 calendar days prior to case plan completion or reunification recommendation or permanency plan change. Sooner if there are new circumstances or new information that affects risk.
Can case be closed? If not, what level of service?	Risk reassessment Safety assessment		All open cases where ALL children are in the home.	Assigned worker	Division 31 = review every six months. Voluntary cases = No more than 30 calendar days prior to case plan completion or case closure recommendation. Involuntary cases = No more than 65 calendar days prior to case plan completion or case closure recommendation. All cases = sooner if new circumstances or new information that affects risk.

*Differential response counties only.
**The standard safety assessment is used for all referrals except substitute care providers. The substitute care provider safety assessment is used when the referral alleges maltreatment by a substitute care provider.

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CALIFORNIA
SDM® HOTLINE TOOLS

Referral Name:_____

Referral #: _____-_____-_____-_____

Date: _____/_____/_____ **County:** _____

STEP I. PRELIMINARY SCREENING

☐ Review of screening criteria is not required
- ☐ Evaluate out
  - ☐ No child under age 18
  - ☐ Duplicate referral that contains no new information
  - ☐ Referred to another county
  - ☐ Allegations of harm in a group home, residential treatment facility, or other institution
- ☐ Safely surrendered baby

If any of the above are marked, the screening decision has been made and the assessment is completed. No further SDM assessments are required.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

A. Screening Criteria (Elicit reporter's concerns and mark all that apply.)

Physical Abuse (if not automatic 24-hour, go to physical abuse tree)
☐ Non-accidental or suspicious injury
- ☐ Death of a child due to abuse AND there is another child in the home (automatic 24-hour)
- ☐ Severe (automatic 24-hour)
- ☐ Other injury (other than very minor unless child is under 1 year old)

☐ Caregiver action that likely caused or will cause injury (other than very minor unless child is under 1 year old)
☐ Prior death of a child due to abuse AND there is a new child, of any age, in the home

Emotional Abuse (go to emotional abuse tree)
☐ Caregiver actions have led or are likely to lead to child's severe anxiety, depression, withdrawal, or aggressive behavior toward self or others
☐ Exposure to domestic violence

Neglect
☐ Severe neglect (if not automatic 24-hour, go to neglect tree)
- ☐ Diagnosed malnutrition (automatic 24-hour)
- ☐ Non-organic failure to thrive
- ☐ Child's health/safety is endangered
- ☐ Death of a child due to neglect AND there is another child in the home (automatic 24-hour)

☐ General neglect (go to neglect tree)
- ☐ Inadequate food
- ☐ Inadequate clothing/hygiene
- ☐ Inadequate/hazardous shelter
- ☐ Inadequate supervision
- ☐ Inadequate medical/mental health care
- ☐ Caregiver absence/abandonment
- ☐ Involving child in criminal activity
- ☐ Failure to protect
  - ☐ Family sexual exploitation
  - ☐ Commercial sexual exploitation:
    - ☐ Child has been commercially sexually exploited and/or sex trafficked while in placement [notify worker for immediate response and notify licensing]
    - ☐ Child has been commercially sexually exploited and/or sex trafficked [not in placement] — provide immediate placement support.)

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☐ Threat of neglect (go to neglect tree)
- ☐ Prior failed reunification or severe neglect, and new child in household
- ☐ Allowing child to use alcohol or other drugs
- ☐ Prior death of a child due to neglect AND there is a new child, of any age, in the home
- ☐ Prenatal substance use
- ☐ Other high-risk birth

Sexual Abuse (go to sexual abuse tree)

☐ Any sexual act on a child by an adult caregiver or other adult in the household, or unable to rule out household member as alleged perpetrator

☐ Physical, behavioral, or suspicious indicators consistent with sexual abuse

☐ Sexual act(s) among siblings or other children living in the home

☐ Family sexual exploitation

☐ Commercial sexual exploitation
- ☐ Child has been commercially sexually exploited and/or sex trafficked while in placement (notify worker for immediate response and notify licensing)
- ☐ Child has been commercially sexually exploited and/or sex trafficked (not in placement) — provide immediate placement support

☐ Threat of sexual abuse
- ☐ Known or highly suspected sexual abuse perpetrator lives with child
- ☐ Severely inappropriate sexual boundaries

B. Screening Decision

☐ Evaluate out: No criteria are marked

For differential response counties, proceed to Step IV-A, Path Decision for Evaluate Out.

For counties not implementing differential response, stop. No further SDM assessments required.

☐ In-person response: One or more criteria are marked

Proceed to Step III, Response Priority

Overrides

☐ In-person response. No criteria are marked, but report will be opened as a referral. No further SDM assessments required. Mark all that apply.
- ☐ Courtesy interview at law enforcement's request
- ☐ Residency verification
- ☐ Response required by court order
- ☐ Local protocol (specify): _____
- ☐ Other (specify): _____

☐ Evaluate out. One or more criteria are marked, but report will be evaluated out. No further SDM assessments required. Mark all that apply.
- ☐ Insufficient information to locate child/family
- ☐ Another community agency has jurisdiction
- ☐ Historical information only

STEP III. RESPONSE PRIORITY

Mark if applicable.
- ☐ Allegation concerns maltreatment by current substitute care provider AND county policy requires response within 24 hours (automatic 24-hour)
- ☐ Child is already in custody (automatic 24-hour)

If not applicable, complete the appropriate decision tree(s).

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A. Decision Trees

PHYSICAL ABUSE

Do ANY of the following apply?
- ☐ Medical care currently required due to alleged abuse
- ☐ Caregiver's behavior is alleged to be dangerous or threatening to child's health or safety (reasonable person standard)
- ☐ Allegation of physical injury to non-mobile child or any child under age 2 (or capability equivalent)

Yes → Within 24 Hours

No ↓

☐ Is there a nonperpetrating caregiver aware of the alleged abuse who is demonstrating a response that is appropriate and protective of the child?

Yes → Within 10 Days

No ↓

Do ANY of the following apply?
- ☐ Child is vulnerable or fearful
- ☐ There is prior history of physical abuse
- ☐ There is current concern that domestic violence will impact the safety of the child within the next 10 days

Yes → Within 24 Hours

No ↓ Within 10 Days

EMOTIONAL ABUSE

- ☐ Child is exhibiting behavior that threatens the health or safety of the child or others AND caregiver is unable or unwilling to seek appropriate help or control the child's behavior
- ☐ Caregiver's behavior is alleged to be cruel, bizarre, or dangerous to the emotional health or safety of the child

Yes → Within 24 Hours

No ↓ Within 10 Days

NEGLECT

Do ANY of the following apply?
- ☐ Child requires immediate medical/mental health evaluation or care
- ☐ Child's physical living conditions are immediately hazardous to health or safety
- ☐ Child is currently unsupervised and in need of supervision
- ☐ Substance-exposed newborn will be discharged within 10 days AND no caregiver appears willing and able to provide for the infant upon discharge

Yes → Within 24 Hours

No ↓ Within 10 Days

SEXUAL ABUSE

☐ Is there current abuse/exploitation as evidenced by disclosure, credible witnessed account, or medical evidence?

No → Within 10 Days

Yes ↓

☐ Is there a nonperpetrating caregiver aware of the alleged abuse/exploitation who is demonstrating a response that is appropriate and protective of the child?

No/ Unknown → Within 24 Hours

Yes ↓ Within 10 Days

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B. Overrides

Policy
Increase to 24 hours whenever:
☐ Law enforcement requests an immediate response;
☐ Forensic considerations would be compromised by slower response; or
☐ There is reason to believe that the family may flee.

Decrease to 10 days whenever:
☐ Child safety requires a strategically slower response;
☐ The child is in an alternative safe environment; or
☐ The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period.

Discretionary
☐ Increase response level
☐ Decrease response level (requires supervisory approval)
Reason: _____

Final Response Priority: ☐ 24 hours ☐ 10 days

Field Update
To be completed by field supervisor, if needed, based on new or additional information. Mark only decisions that have changed.

New Decisions

Screening:	☐ Evaluate out			
Response Priority:	☐ 24 hours	☐ 10 days		
Path:	☐ No response	☐ Path 1	☐ Path 2	☐ Path 3

Basis (state reason for change based on SDM criteria and new or additional information): _____
_____

STEP IV. PATH OF RESPONSE DECISION

A. Path Decision for Evaluate Out (for differential response counties only)
Review the following factors/considerations when making the path decision. Mark yes or no for each as applicable based on information reported and/or available at the time of referral. If unknown at the time of report, answer no.

Yes	No	
☐	☐	Prior investigations (indicate number of prior investigations) ☐ One or two ☐ Three or more
☐	☐	Prior failed reunification, or death of a child not due to abuse or neglect
☐	☐	Current caregiver substance abuse, domestic violence, or mental health issues
☐	☐	Identified need that can be addressed with community services ☐ Clothing ☐ Housing ☐ Counseling ☐ Medical ☐ Education ☐ Food ☐ Financial ☐ Other (specify):_____
☐	☐	Other (specify): _____

Path Decision (mark one): ☐ No response ☐ Path 1

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B. Path Decision for In-Person Response (for differential response counties only)
Review the following factors/considerations when making the path decision. Mark yes or no for each as applicable based on information reported and/or available at the time of referral. If unknown at the time of report, answer no.

(If final response priority is 24 hours)
Apply automatic Path 3? ☐ Yes ☐ No

Yes	No	
☐	☐	Likelihood of caregiver arrest or juvenile court involvement as a result of alleged incident
☐	☐	Allegation involves sexual abuse
☐	☐	Prior investigations (indicate number of prior investigations) ☐ One or two ☐ Three or more
☐	☐	Prior child protective services (previous ongoing case)
☐	☐	Four or more alleged child victims
☐	☐	Caregiver has a current mental health issue ☐ Primary caregiver ☐ Secondary caregiver ☐ Both caregivers
☐	☐	Primary caregiver has a history of abuse/neglect as a child
☐	☐	Any child with (mark all that apply): ☐ Mental health/behavioral problems ☐ Developmental or physical disability ☐ Medically fragile or failure to thrive ☐ Positive toxicology screen at birth ☐ Delinquency history
☐	☐	Housing is unsafe or family is homeless
☐	☐	Prior injury to a child due to abuse or neglect
☐	☐	Domestic violence in the last 12 months
☐	☐	Caregiver has a current substance abuse issue ☐ Primary caregiver ☐ Secondary caregiver ☐ Both caregivers
☐	☐	Other (specify): _____

Path Decision (mark one): ☐ Path 2 ☐ Path 3

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CALIFORNIA
SDM® HOTLINE TOOLS
DEFINITIONS

STEP I. PRELIMINARY SCREENING

Review of screening criteria is not required

- Evaluate out.
  - » No child under age 18. The current referral may allege abuse or neglect, but the alleged victim is 18 years of age or older (including non-minor dependents).
  - » Duplicate referral that contains no new information. The report duplicates an existing referral (this is commonly known as a secondary referral). This report does not contain new allegations from an existing referral.
  - » Referred to another county. A referral has been received for a child who lives in another county. The caller was both referred to that county and provided with contact information, or the county was notified and the referral was recorded in that county. Refer to local protocol for this type of referral.
  - » Allegations of harm in a group home, residential treatment facility, or other institution. The allegations concerning harm or threatened harm are limited to harm or threatened harm by facility staff in a group home, residential treatment facility, or other institution.
- Safely surrendered baby. The referral concerns a child 72 hours of age or younger whose caregiver has voluntarily surrendered physical custody of the child to any employee on duty at a public or private hospital emergency room or any additional site approved as a Safe Surrender Site.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

A. Screening Criteria (Elicit reporter's concerns and mark all that apply.)
Consider age, developmental status, and other child vulnerabilities when assessing referrals for allegations of abuse or neglect.

Physical Abuse (if not automatic 24-hour, go to physical abuse tree)

Non-accidental or suspicious injury
The child has a current or previously unreported injury or impairment AND the caregiver deliberately caused the injury/impairment OR there is a basis to be suspicious that a caregiver caused it and it was non-accidental. Basis for suspicion may include but is not limited to:

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- Physician reports that the injury type is consistent with non-accidental injuries;
- Injury to a non-ambulatory child with no plausible alternative explanation;
- Explanation for injury does not match injury;
- Injury is in the shape of an object (e.g., loop marks); or
- Credible disclosure by the child to the reporting party or other adult.

Identify the type of non-accidental or suspicious physical injury.

- Death of a child due to abuse AND there is another child in the home (automatic 24-hour). There was a death of a child in the home and circumstances are suspicious for abuse or abuse has been identified as the cause of death in this report or investigation, AND other children are in the care of identified/suspected perpetrator.

- Severe (automatic 24-hour). A severe injury is one that, if left untreated, would cause permanent physical disfigurement, permanent physical disability, or death. Include visible injuries and suspected injuries due to symptoms such as loss of consciousness, altered mental status, inability to use an arm, inability to bear weight, etc.

- Other injury (other than very minor unless child is under 1 year old). Any visible or suspected injury that is not severe. Any "other" non-accidental injury to a child under 1 year old should not be considered very minor.

  » Any non-accidental or suspicious injury to a child who is non-ambulatory, including very minor injuries such as welts, scratches, abrasions, swelling, or injuries that cause even brief pain.

  » Injuries caused to a child during a domestic violence incident.

  » "Other" injuries may require assessment/treatment but are not life-threatening and are not likely to result in temporary or permanent disability or disfigurement. These may include bruises, welts, or abrasions in areas of the body that do not pose a threat of serious injury or disfigurement (arms, legs, buttocks).

  » Very minor injuries are defined as those that involve only mild redness or swelling, minor welts/scratches/abrasions, or brief and minor pain.

Caregiver action that likely caused or will cause injury (other than very minor unless child is under 1 year old)

It is not necessary for a reporter to determine that an injury occurred. Examples of caregiver action that is likely to have caused or will cause injury include but are not limited to the following:

- Shaking or throwing an infant or child under 3 years old.

- Inappropriate physical discipline, such as choking, suffocation, tying child up, locking child in closet/kennel, physical activity exceeding child's ability to perform, etc.

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- Hitting a child with enough force or using objects to strike a child that could cause a significant injury, such as a broken bone, concussion, significant bruising or lacerations, or internal injuries.

- Exposing a child to dangerous weather or environmental hazards (e.g., locking child out of the home, confining child to garage with dangerous fumes/exhaust, dropping child off far from home with no resources to get to a safe place).

- Dangerous behavior toward the child or in immediate proximity of the child, including domestic violence incidents that occur while the child is present. Consider combination of child location, type of incident (e.g., pushing, throwing objects, use of a weapon), and child vulnerability.

- Caregiver has made credible threats to cause physical harm to the child that, if carried out, would constitute child abuse, and it is likely that, without intervention, the caregiver will carry out these threats. **If threats are clearly for the sole purpose of emotional abuse, mark as emotional abuse. If the purpose cannot be discerned, mark both this section and "emotional abuse."**

<u>Prior death of a child due to abuse AND there is a new child, of any age, in the home</u>
There was a death of a child in the home due to abuse or circumstances were suspicious for abuse prior to the current referral AND there is a new child currently in the care of the identified/suspected perpetrator.

Emotional Abuse (go to emotional abuse tree)

<u>Caregiver actions have led or are likely to lead to child's severe anxiety, depression, withdrawal, or aggressive behavior toward self or others</u>
Caregiver action(s), statement(s), or threat(s) have led or are likely to lead to child's emotional damage (e.g., severe anxiety, depression, withdrawal); behavioral concerns (e.g., untoward aggressive behavior toward self or others); and/or adverse impact on the child's emotional development, including but not limited to delayed speech development, abnormal attachment behaviors, and impulse control behaviors. The adverse impact may result from a single event or from a consistent pattern of behavior and may be currently observed and/or predicted as supported by evidence-based practice. Types of emotional maltreatment include but are not limited to the following:

- Rejecting and/or degrading the child.

- Isolating and/or victimizing the child by means of cruel, unusual, or excessive methods of discipline.

- Exposing the child to brutal or intimidating acts or statements, including but not limited to:

  » Harm or threatened harm to animals;

  » Threats of suicide or harm to family members (including the child);

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» Confining the child in places such as closets or animal cages; or

» Consistently scapegoating the child; consistently berating, belittling, blaming, targeting, or shaming the child.

The adverse impact on the child may or may not be apparent depending on the child's age, cognitive abilities, verbal ability, and developmental level. Adverse impact is not required if the action/inaction is a single incident that demonstrates a serious disregard for the child's welfare.

Exposure to domestic violence
The child has witnessed, intervened in, or is otherwise aware of physical altercations, serious verbal threats, or intimidation between adults in the home. These incidents may occur on more than one occasion OR on a single occasion that involved weapons, resulted in any injury to an adult, or resulted in arrest/court involvement.

Domestic violence perpetrators, in the context of the child welfare system, are parents and/or caregivers who engage in a pattern of coercive control against one or more intimate partners. This pattern of behavior may continue after the end of a relationship or when the partners no longer live together. The alleged perpetrator's actions often directly involve, target, and impact any children in the family.

If a child has been injured or is threatened with injury, also mark "non-accidental or suspicious injury" or "caregiver action that likely caused or will cause injury" under "Physical Abuse."

Neglect

Severe neglect (if not automatic 24-hour, go to neglect tree)

- Diagnosed malnutrition (automatic 24-hour). The child has a current diagnosis by a qualified medical professional of severe malnutrition due to inadequate or unbalanced diet, OR a qualified medical professional states that there are indicators of malnutrition but a formal diagnosis has not yet been made.

- Non-organic failure to thrive. The child has a current diagnosis by a qualified medical professional of non-organic failure to thrive, OR a qualified medical professional states that there are indicators of failure to thrive but a formal diagnosis has not yet been made.

- Child's health/safety is endangered. The caregiver has willfully not provided adequate clothing, shelter, supervision, care, or medical care AND there is imminent risk of serious illness or injury, or serious illness or injury has already occurred. Consider child's age, behavior, and vulnerability.

  For example:

  » The child's clothing is so inappropriate for weather that the child suffered hypothermia or frostbite;

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» Housing conditions result in lead poisoning, severely exacerbated asthma due to smoke exposure, and/or multiple bites from pest infestations;

» There is methamphetamine production in the home/residence;

» Medical care has not been provided for an acute or chronic condition and, as a result, the child has required or is likely to require hospitalization or surgery; or the condition may worsen to the extent that unnecessary permanent disability, disfigurement, or death results;

» Caregiver is willfully not meeting child's mental health needs and child has demonstrated suicidal or homicidal behavior/ideation;

» Child is not supervised to the extent that the child has been seriously injured, is at risk of being seriously injured, or avoided serious injury only due to intervention by a third party;

» A young child is left in a motor vehicle during extreme temperature conditions;

» A caregiver behaves recklessly in proximity to child (e.g., driving under the influence as found by law enforcement, using weapons, etc.); or

» Caregiver is breastfeeding while using dangerous substances (type of substances and/or amount resulted in or is likely to result in serious injury/illness to child).

- Death of a child due to neglect AND there is another child in the home (automatic 24-hour). There has been a death of a child in the home due to neglect or circumstances that are suspicious for neglect, AND another child is currently in the care of the identified/suspected perpetrator.

General neglect (go to neglect tree)
Consider age/developmental status of children. Minor or no injury or illness has occurred.

- Inadequate food. The caregiver does not provide sufficient food to meet minimal requirements for the child to maintain health and growth. The child experiences unmitigated hunger; lack of food has a negative impact on school performance. Caregiver's use of food stamps and/or food pantries as sources of food should not be considered failure to provide food.

- Inadequate clothing/hygiene. The caregiver has failed to meet the child's basic needs for clothing and/or hygiene to the extent that the child's daily activities are negatively impacted and/or the child develops or suffers a worsening medical condition. Examples include but are not limited to:

» Sores, infection, or severe diaper rash;

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» Clothing that is inappropriate for the weather and results in health or safety concerns;

» Inability to attend school due to lack of clean clothing; and/or

» Experiencing shame or isolation from peers due to poor hygiene/extreme body odor.

- Inadequate/hazardous shelter. The residence is unsanitary and/or contains hazards that have led or could lead to injury or illness of the child if not resolved. Examples include but are not limited to:

  » Housing that is an acute fire hazard or has been condemned;

  » Exposed heaters, gas fumes, or faulty electrical wiring;

  » No utilities (e.g., water, electricity, heat source if needed) AND these are necessary based on current conditions and age/developmental status or special needs of the child;

  » Pervasive and/or chronic presence of rotting food, human/animal waste, or infestations;

  » Presence of poisons, guns, or drugs within reach of child; and/or

  » Lack of safe sleeping arrangements for infant/child.

- Inadequate supervision. Caregiver is present but not attending to the child, or caregiver has made inadequate care arrangements for the child. Injury has occurred due to lack of supervision or been avoided due to third-party intervention. Examples include but are not limited to the following:

  » Caregiver fell asleep in the apartment/house and young child wandered from the home into the hallway/street.

  » Child plays with dangerous objects (e.g., sharp knife, gun, matches).

  » Non-mobile infant left in car seat or carrier for extended periods of time.

  » Caregiver is unable to care for child due to substance use, mental illness, or developmental disability.

  » Caregiver is unable to protect child in the home from a sibling with violent behavior.

- Inadequate medical/mental health care. Child has a mild to moderate condition, and the caregiver is not seeking or following medical treatment; OR the child has a severe,

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chronic condition and the caregiver's care is partial, but important components of the child's medical needs are unmet.

- Caregiver absence/abandonment.

  » Caregiver is unable to care for the child due to incarceration, hospitalization, or unavoidable absence AND **there is no safe adult to care for the child**. If the caregiver is incarcerated, hospitalized, or absent and has made a plan of care for the child with a safe adult or is otherwise able to safely mitigate the impact of his/her absence on the child, this item should not be selected.

  » Caregiver has deserted the child with no apparent plans for return. Abandonment may be indicated by quitting jobs, establishing another residence, and taking clothing and other belongings.

  » Child is being discharged from a facility and caregiver refuses to accept child back into his/her home AND has not participated in discharge planning or caregiver cannot be found.

  » Caregiver has kicked child out of the home/refuses child entry to the home and has not provided a safe alternative.

  » Caregiver left child with family or friends who state an intention to discontinue care and caregiver refuses to accept child back or cannot be located.

  » Child is or has been left without an identified caregiver for a period of time inappropriate to the child's age or developmental status. Consider presence of support systems such as relatives and neighbors and child's ability to access support systems by phone or access within immediate walking distance.

- Failure to protect.

  » Caregiver knowingly left child in the care of a person known to neglect or abuse children; a person unknown to the caregiver; or a person known to be violent, use alcohol/drugs, or have serious mental health concerns to the extent that his/her ability to provide care is significantly impaired;

  » Caregiver does not intervene despite knowledge (or reasonable expectation that the caregiver should have knowledge) that the child is being harmed (includes physical, sexual, or emotional abuse or neglect) by another person;

  OR

  » A child has been exploited by a third party, and the person responsible for the child's care has failed in protecting or been unable to protect the child from being commercially sexually exploited and/or sex trafficked. This includes situations where the person responsible for the care of the child has been coerced or otherwise been unable to prevent exploitation.

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- Children and youth aged 17 years old and younger are sexually exploited when they have engaged in, solicited for, or been forced to engage in sexual conduct or performance of sexual acts (e.g., stripping) in return for a benefit, such as money, food, drugs, shelter, clothing, gifts, or other goods, or for financial or some other gain for a third party. The sexual conduct may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed.

- Commercial sexual exploitation of children/youth/young adults may include prostitution, pornography, trafficking for sexual purposes, and other forms of sexual exploitation. The youth is treated as a sexual object and as a commercial object. The sexual exploitation of the child may profit a much wider range of people than the immediate beneficiary of the transaction.

- Involving child in criminal activity. The caregiver causes the child to perform or participate in illegal acts that:

  » Create danger of serious physical or emotional harm to the child;
  » Expose the child to being arrested; or
  » Force a child to act against his/her wishes.

Threat of neglect (go to neglect tree)
No event has occurred; however, conditions exist that create a substantial likelihood that the child will be neglected. **Caregiver has not demonstrated capacity to meet child's basic needs without external supports and external supports are no longer present.**

- Prior failed reunification or severe neglect, and new child in household. There is credible information that a current caregiver had one or more children for whom there was:

  » A failed reunification as a result of child abuse or neglect; OR

  » A current caregiver was previously substantiated for severe neglect;

  AND

  » A new child is now living in the home and conditions exist that create a substantial likelihood that the child will be neglected.

- Allowing child to use alcohol or other drugs. Caregiver provides (offers or knowingly allows the child to consume) alcohol, illegal drugs, or inappropriate prescription drugs to a child to the extent that it could endanger the child's physical health or emotional well-being or result in exposure to danger because the child's thinking and/or behavior are impaired. Consider child's age and substance type, including the following:

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» Providing methamphetamine, heroin, cocaine, or similar drugs to a child of any age.

» Providing enough alcohol to result in intoxication.

» Providing alcohol over time so that the child is developing a dependency.

» Providing medications (includes prescription and over-the-counter) that are not prescribed for the child, for the purpose of altering the child's behavior or mood.

» Providing glue or other inhalants to a child of any age.

Examples of substance use that should not be included are:

» Use of small amounts of alcohol for religious ceremonies; and

» An older child is permitted to try a small amount of alcohol at a family occasion that did not result in intoxication.

- Prenatal substance use. There is a positive toxicology finding for a newborn infant or his/her mother OR other credible information that there was prenatal substance abuse by the mother (e.g., witnessed use, self-admission);

  AND

  There is indication that the mother will continue to use substances, rendering her unable to fulfill the basic needs of the infant upon discharge from the hospital. Indicators may include, but are not limited to, the type of drug (the more addictive the drug, the more likely there will be continued use), pattern of past use, behavior during hospitalization, statements by the mother or others regarding use, AND willingness/ability to care for infant. Willingness/ability to provide care may be indicated by observation of the mother's preparation for care of a newborn, her engagement in prenatal care, appropriate food, lodging, clothing, past safe care of children, engagement in substance abuse treatment services, availability of and willingness to use a support network, etc.

- Other high-risk birth. No acts or omissions constituting neglect have yet occurred; however, conditions are present that suggest that the only reasons neglect has not occurred are the external supports of the hospitalization or the limited time since birth. Examples include but are not limited to the following:

  » Sole caregiver or both caregivers have not attended to the newborn in the hospital.

  » Teen mother has no support system, and maturity level suggests she will be unable to meet the newborn's basic needs.

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» A mother of any age with apparent physical, emotional, or cognitive limitations has no support system and may be unable or unwilling to meet the newborn's basic needs.

» A child was born with medical complications, and sole caregiver's or both caregivers' response suggests caregiver(s) will be unable to meet the child's exceptional needs (e.g., does not participate in medical education to learn necessary care, indicates denial of diagnosis, etc.).

- Prior death of a child due to neglect AND there is a new child, of any age, in the home. There has been a death of a child in the home due to neglect or circumstances are suspicious for neglect prior to the current referral, AND new children are currently in the care of the identified/suspected perpetrator.

Sexual Abuse (go to sexual abuse tree)

Any sexual act on a child by an adult caregiver or other adult in the household, or unable to rule out household member as alleged perpetrator.
Based on verbal or nonverbal disclosure, medical evidence, or credible witnessed act. If child knows that the alleged perpetrator is not a household member but does not know his/her identity, DO NOT MARK.

Physical, behavioral, or suspicious indicators consistent with sexual abuse.
Suspicious indicators include but are not limited to the following:

- Toddler or elementary school–aged child displays highly sexualized aggressive behaviors.

- Pre-adolescent child has initiated sexual acts or activities with caregivers, family members, or peers that are outside age-appropriate exploration or development, and this has led to a concern that he/she is a victim of sexual abuse.

- Child complains of pain in the genital or anal area AND there are other indications of sexual abuse.

Sexual act(s) among siblings or other children living in the home.
Children living in the home engage in sexual behavior that is outside of normal exploration or involves coercion or violence.

Sexual exploitation.
Caregiver involves the child in obscene acts or engages the child in prostitution or pornography. This includes a child being commercially sexually exploited and/or sex trafficked by or with knowledge and consent of caregiver.

- Children and youth aged 17 years old and younger are sexually exploited when they have engaged in, solicited for, or been forced to engage in sexual conduct or performance of sexual acts (e.g., stripping) in return for a benefit, such as money, food,

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drugs, shelter, clothing, gifts, or other goods, or for financial or some other gain for a third party. The sexual conduct may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed.

- Commercial sexual exploitation of children/youth/young adults may include prostitution, pornography, trafficking for sexual purposes, and other forms of sexual exploitation. The youth is treated as a sexual object and as a commercial object. The sexual exploitation of the child may profit a much wider range of people than the immediate beneficiary of the transaction.

Threat of sexual abuse.
No sexual act or exploitation has occurred; however, the caregiver behaves in ways that create a substantial likelihood that the child will be sexually abused.

- Known or highly suspected sexual abuse perpetrator lives with child. An individual with a known or suspected record for sexual crimes lives in the same residence as the child.

- Severely inappropriate sexual boundaries. Note: This does not include incidents that are accidental or inadvertent unless the report indicates that the behavior is persistent or frequently occurring.

  » Adults in the home allow children to see sexually explicit material, witness sexual acts, or hear sexual language that is inappropriate to their age/developmental status.

  AND

  » This has resulted in the child exhibiting age-inappropriate sexual behavior OR emotional distress.

  » Adult(s) in the household exhibits behaviors suggesting the purpose is sexual gratification for the adult.

B. Screening Decision

Evaluate out: No criteria are marked.
Mark this decision if no criteria in Section A are marked, which means that the report does not meet statutory requirements for an in-person response. For differential response counties, proceed to Step IV-A, Path Decision for Evaluate Out. For counties not implementing differential response, stop. No further SDM assessments required.

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In-person response: One or more criteria are marked.
Mark this decision if any criteria in Section A are marked, which means that at least one reported allegation meets statutory requirements for an in-person response. Proceed to Step III, Response Priority.

Overrides

In-person response. No criteria are marked, but report will be opened as a referral. No further SDM assessments required. Mark all that apply.
Mark this decision if no criteria in Section A are marked, which means that the report does not meet statutory requirements for an in-person response; however, a referral will be opened in the child welfare services case management system (CWS/CMS) for an in-person response due to local protocol. Indicate the type of referral (i.e., courtesy interview at law enforcement's request, residency verification, response required by court order, local protocol, or other).

Evaluate out. One or more criteria are marked, but report will be evaluated out. No further SDM assessments required. Mark all that apply.

- Insufficient information to locate child/family. The caller was unable to provide enough information about the child's identity and/or location to enable an in-person response. Mark ONLY after following county protocol for attempting to discern identity/location from information provided by caller.

- Another community agency has jurisdiction. Local protocol determines that an agency such as law enforcement, probation, or court will be the investigating entity for this issue AND a child welfare response is not required.

- Historical information only. Child is at least 10 years old AND the alleged maltreatment occurred more than one year ago, AND there were no reports of abuse or neglect since the alleged incident, AND the conditions that contributed to the alleged incident are no longer present. If reported incident is sexual abuse, all of the above criteria must apply AND the reported perpetrator must be either an unidentifiable non-household member, or deceased.

STEP III. RESPONSE PRIORITY

A. Decision Trees

Physical Abuse

Medical care currently required due to alleged abuse.
Medical care is immediately necessary and if not provided will seriously and possibly permanently affect the child's health and well-being. This includes treatment and/or evaluation of an injury that is needed or currently in progress. It does not include medical examination completed solely for forensic purposes.

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Caregiver's behavior is alleged to be dangerous or threatening to child's health or safety (reasonable person standard).
Caregiver acted in brutal or dangerous ways; or the caregiver has made threats (other than empty threats or threats made solely for intimidation) of brutal or dangerous acts toward the child AND absent intervention, it is likely that the child will experience an injury within the next 10 days.

Include concerns of caregiver substance use/abuse or current mental health issues that may increase the risk of physical injury or result in physical injury.

Examples include but are not limited to:

- Hitting with closed fist;
- Hitting child's head, back, or abdomen with substantial force;
- Choking, kicking, or hitting with belt buckle or other dangerous object;
- Using restraints;
- Poisoning; or
- Other actions that could reasonably result in severe injury, such as:
  - » Dangling the child from heights;
  - » Exposing the child to dangerous temperature extremes; or
  - » Throwing objects at the child that could cause severe injury.

Allegation of physical injury to non-mobile child or any child under age 2 (or capability equivalent).
The child has not reached his/her second birthday, or a child of any age has the capability of a child younger than 2 years of age due to developmental, physical, or emotional disability.

Is there a nonperpetrating caregiver aware of the alleged abuse who is demonstrating a response that is appropriate and protective of the child?
A nonperpetrating caregiver is aware that physical abuse has been alleged AND demonstrates the ability to prevent the alleged perpetrator from having access to the child. The nonperpetrating caregiver will not pressure the child to change his/her statement and will obtain or has obtained medical treatment for the child as needed.

Child is vulnerable or fearful.

- A child is vulnerable if, due to age, developmental status, or physical disability, he/she is unable to protect him/herself and/or will not be seen within the next week by other adults who would report concerns (e.g., school personnel).

- The child expresses credible fear of going/remaining home.

There is prior history of physical abuse.
There is credible information that there are one or more prior investigations for physical abuse. (Include all investigations assigned for in-person response. If for a differential response county, include Path 2 and Path 3 referrals.)

Credible information includes statements by a reporter, verified information in CWS/CMS, or police reports.

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There is current concern that domestic violence will impact the safety of the child within the next 10 days.
There are physical altercations between the caregiver and another adult living in the home. Include situations where one of the adults does not live in the home but has substantial contact in the home, or has lived in the home but continues to behave in threatening ways.

Emotional Abuse

Child is exhibiting behavior that threatens the health or safety of the child or others AND caregiver is unable or unwilling to seek appropriate help or control the child's behavior.
Examples of behavior that threatens the health or safety of the child or others include but are not limited to the following:

- Attempted or threatened suicide.
- Cutting or other self-harmful behavior.
- Violent behavior toward others involving weapons.
- Threats of violence that involve weapons and there is reason to believe the child will carry out the threat.
- Violence toward very young or vulnerable children.
- Torturing or killing animals.
- Fire-setting behavior.

Caregiver's behavior is alleged to be cruel, bizarre, or dangerous to the emotional health or safety of the child.
Examples include but are not limited to the following:

- The caregiver harms him/herself, others, or pets in the child's presence.
- The caregiver threatens to harm him/herself, others, or the child's pet.
- Unusual forms of discipline that rely on humiliation, fear, and intimidation, such as forcing a 10-year-old to wear diapers.
- Extreme rejection of the child, such as not speaking to the child for extended periods, acting as if the child is not present for long periods, or misusing time-out technique by using time limits far beyond what would be appropriate for the child's age/developmental status.
- Domestic violence incidents that involve weapons or result in serious injury to any adult, or during which the child attempts to intervene or is directly in the path of violence.

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Neglect

Child requires immediate medical/mental health evaluation or care.
Medical or mental health care is necessary. If not provided within the next 10 days, the child's health and well-being will be seriously, and possibly permanently, affected. In addition to medical conditions, this includes extreme dental and mental health conditions.

Child's physical living conditions are immediately hazardous to health or safety.
Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening. Examples include but are not limited to the following:

- Leaking gas from stove or heating unit.
- Substances or objects accessible to the child that may endanger his/her health and/or safety.
- Lack of water or utilities (e.g., heat, plumbing, electricity) and no alternative or safe provisions have been made.
- Open/broken/missing windows.
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food that threatens the child's health.
- Child has suffered serious illness or significant injury 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 and other weapons are not locked.
- Illegal drug production in the home.

Child is currently unsupervised and in need of supervision.
Based upon local community standards, the child is not receiving appropriate supervision from his/her caregiver, and there is no appropriate alternative plan for supervision within the next 10 days. Examples include:

- Child is currently alone (time period varies with age and developmental stage).
- Caregiver does not attend to the child to the extent that need for care/protection goes unnoticed or unmet (e.g., child being harmed by another person in the home/failure to protect; the caregiver is present, but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards; a child with some suicidal ideation is not closely monitored).
- Child is presently receiving inadequate and/or inappropriate child care arrangements.

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- Child has been abandoned and has no caregiver willing and able to provide care for a minimum of 10 days.

Substance-exposed newborn will be discharged within 10 days AND no caregiver appears willing and able to provide for the infant upon discharge.
A newborn who is substance-exposed or otherwise at high risk has been discharged or will be discharged within 10 days, AND the sole caregiver or both caregivers appear unwilling and unable to provide for the child upon discharge OR there is reason to believe the caregiver will remove the child against medical advice. Indicators include the following:

- The caregiver uses substances, such as methamphetamine, heroin, or cocaine, that typically result in severely impaired ability to function.
- The frequency and/or quantity of caregiver substance use suggests a high probability that he/she will be unable to meet the needs of the newborn upon discharge.
- Prior failed reunification.

Sexual Abuse

Is there current abuse/exploitation as evidenced by disclosure, credible witnessed account, or medical evidence?
Disclosure may be verbal or nonverbal (e.g., extreme sexual acting-out behavior). Medical evidence includes medical findings related to sexual abuse and suspicious findings such as sexually transmitted diseases in young children.

Is there a nonperpetrating caregiver aware of the alleged abuse/exploitation who is demonstrating a response that is appropriate and protective of the child?
A nonperpetrating caregiver is aware that sexual abuse has been alleged, and he/she supports the child's disclosure AND demonstrates the ability to prevent the alleged perpetrator from having access to the child. The nonperpetrating caregiver will not pressure the child to change his/her statement and will obtain or has obtained medical treatment for the child as needed.

B. Overrides

Policy

Increase to 24 hours whenever:

Law enforcement requests an immediate response.
A law enforcement officer is requesting an immediate child protective services response.

Forensic considerations would be compromised by slower response.
Physical evidence necessary for the investigation will be compromised if the investigation does not begin immediately, OR there is reason to believe statements will be altered if interviews do not begin immediately.

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There is reason to believe that the family may flee.
The family has stated an intent to flee or is acting in ways that suggest an intent to flee, OR there is a history of the family fleeing to avoid investigation.

Decrease to 10 days whenever:

Child safety requires a strategically slower response.
The child's current location is such that initiating contact may create a threat to the child's safety OR the value of coordinating a multi-agency response outweighs the need for immediate response.

The child is in an alternative safe environment.
The child is no longer in the same place or no longer with the caregiver who is the alleged perpetrator, and the child is not expected to return within the next 10 days (five days in Los Angeles).

The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period.
The incident being reported occurred at least six months prior to the report AND no other maltreatment is alleged to have occurred in the intervening time period.

STEP IV. PATH OF RESPONSE DECISION

A. Path Decision For Evaluate Out (for differential response counties only)
For all referrals that are evaluated out, mark yes or no to indicate whether any of the following are applicable based on information reported or available at the time of the report. If unknown at the time of report, answer no.

Prior investigations (indicate number of prior investigations)
Credible information shows that there have been prior investigated referrals alleging maltreatment by a current caregiver of the child. (Credible information includes statements by a reporter, verified information in CWS/CMS, or police reports.) Include all allegation types and all dispositions (e.g., substantiated, inconclusive, unfounded). For differential response history, include all Path 2 and Path 3 responses. If prior investigation history is present, indicate the number of prior investigations as either one or two, or three or more.

Prior failed reunification, or death of a child not due to abuse or neglect
Credible information shows that a current caregiver of the child has or has had a prior failed reunification for other children in his/her care, or a child in his/her care has died (not due to substantiated abuse or neglect).

Current caregiver substance abuse, domestic violence, or mental health issues
Credible information shows that:

- A caregiver has a substance abuse problem.
  - » The caregiver is diagnosed with chemical dependency or abuse AND is currently using. Current use does not require that the caregiver be under the

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influence at the moment of the call, but that the caregiver has used within the past two weeks and has not entered into a formal or informal program to achieve abstinence; OR

» The caregiver is using illegal drugs; OR

» The caregiver's alcohol use suggests a probability that dependency or abuse exists, such as blackouts, secrecy, negative effects on job or relationships, identified drinking patterns, etc.

- There are physical altercations between the caregiver and another adult living in the home within the past year, regardless of whether children were present. This includes situations where one of the adults does not live in the home but has substantial contact in the home, or has lived in the home but continues to behave in threatening ways.

- A caregiver has current mental health concerns based on a diagnosis of a major mental illness (e.g., schizophrenia, bipolar disorder, depression) or exhibits symptoms that suggest a probability that such a diagnosis exists, such as hearing voices, paranoid thoughts, severe mood changes, suicidal thoughts or behavior, or extremely depressed affect.

Identified need that can be addressed with community services
The reporter describes a service or resource need that does not rise to the level of screening threshold but could be addressed through a community agency.

Other (specify)
Specify any other information that was used in determining the final path decision for evaluate out.

B. Path Decision for In-Person Response (for differential response counties only)

Likelihood of caregiver arrest or juvenile court involvement as a result of alleged incident
If conditions alleged by the reporter are true, they would constitute a crime against the child or would constitute the basis for a juvenile court dependency petition.

Allegation involves sexual abuse
Current allegation is for sexual abuse.

Prior investigations (indicate number of prior investigations)
Credible information shows that there have been prior investigated referrals alleging maltreatment by a current caregiver of the child. (Credible information includes statements by a reporter, verified information in CWS/CMS, or police reports.) Include all allegation types and all dispositions (e.g., substantiated, inconclusive, unfounded). For differential response history, include all Path 2 and Path 3 responses. If prior investigation history is present, indicate the number of prior investigations as either one or two, or three or more.

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Prior child protective services (previous ongoing case)
There has been an open family maintenance, family reunification, or permanency planning case involving any current caregiver; or there have been previous ongoing child protective services in another jurisdiction.

Four or more alleged child victims
There are four or more children residing in the home who are alleged as victims of abuse or neglect in the current incident. Do not count children alleged to be "at risk" of abuse and/or neglect.

Caregiver has a current mental health issue
There is credible information that the primary, secondary, or both caregivers have a current mental health concern based on diagnosis of a major mental illness (e.g., schizophrenia, bipolar disorder, depression) or exhibit symptoms suggesting a probability that such a diagnosis exists, such as hearing voices, paranoid thoughts, severe mood changes, suicidal thoughts or behavior, or extremely depressed affect.

Primary caregiver has a history of abuse/neglect as a child
There is credible information that the primary caregiver was abused or neglected as a child.

Any child with (mark all that apply):

- Mental health/behavioral problems not related to a physical or developmental disability (includes ADHD/ADD). This could be indicated by a *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnosis, receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking psychoactive medication.

- Developmental or physical disability, defined as a severe, chronic impairment that creates substantial functional limitations in three or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, potential for independent living, and potential for economic self-sufficiency as an adult.

- Medically fragile or failure to thrive, defined as having a diagnosed medical condition that can become unstable and change abruptly, resulting in a life-threatening situation (e.g., uncontrolled diabetes, required use of monitor, child is non-ambulatory and requires 24-hour care, required nasal gastric or gastronomy tube, tracheotomy) or diagnosis of failure to thrive.

- Positive toxicology screen at birth. Any child had a positive toxicology screen for alcohol or another drug at birth.

- Delinquency history. Any child in the household has been referred to juvenile court for delinquent or status-offense behavior. Status offenses that have not been brought to court attention but have created stress within the household should also be scored, such as children who run away or are habitually truant.

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Housing is unsafe or family is homeless

- The family has housing, but the current housing situation is physically unsafe to the extent that it does not meet the health or safety needs of the child (e.g., exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, rotting food).

- The family is homeless or was about to be evicted at the time the investigation began. Consider as homeless people who are living in a shelter and those living on a short-term basis with relatives or friends.

Prior injury to a child due to abuse or neglect
There is credible information that a current caregiver injured a child due to abuse or neglect prior to the current allegation.

Domestic violence in the last 12 months
There were physical altercations between the caregiver and another adult living in the home within the past year, regardless of whether children were present. This includes situations where one of the adults does not live in the home but has substantial contact in the home, or has lived in the home and continues to behave in threatening ways.

Caregiver has a current substance abuse issue

- The caregiver is diagnosed with chemical dependency or abuse AND is currently using. Current use does not require that caregiver be under the influence at the moment of the call, but that the caregiver has used within the past two weeks and has not entered into a formal or informal program to achieve abstinence; OR

- The caregiver is using illegal drugs; OR

- The caregiver's alcohol use suggests a probability that dependency or abuse exists, such as blackouts, secrecy, negative effects on job or relationships, identified drinking patterns, etc.

Specify whether this applies to the primary, secondary, or both caregivers.

Other (specify)
Specify any other critical risk factor that was used in determining the final path decision for in-person response.

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CALIFORNIA
SDM® HOTLINE TOOLS
POLICY AND PROCEDURES

The purpose of the hotline tools is to assess:

- Whether a referral meets the statutory threshold for an in-person CWS response;
- If not, whether a referral to an alternative community response is appropriate; and
- If so, how quickly to respond and the path of response.

	Preliminary Screening and Appropriateness of a Child Abuse/Neglect Report for Response	**Response Priority**	**Path of Response Decision***
Which Cases	All referrals that are created in CWS/CMS.	All referrals that meet statutory threshold for an in-person response, per the Preliminary Screening and Appropriateness of a Child Abuse/Neglect Report for Response tools.	All referrals that did not meet the statutory threshold for in-person response are assessed using A, Path Decision for Evaluate Out. All referrals that meet statutory threshold for in-person response are assessed using B, Path Decision for In-Person Response.
Who	Worker receiving the referral.	Worker receiving the referral.	Worker receiving the referral OR the designated differential response worker.
When	Immediately upon receipt of the call.	Immediately upon receipt of the call.	Referrals with a 24-hour response priority—complete immediately. Referrals with a 10-day response priority—complete within 24 hours. Referrals that are evaluated out—complete within five working days.
Decision	Does the referral meet statutory threshold for in-person CWS response (yes or no)?	How quickly to respond. First face-to-face contact should begin or be attempted within 24 hours or within 10 days.	Records the path of response decision and documents criteria present at the time of the referral.

*Path of response refers to the response track for referrals under the State of California differential response system. Refer to your local differential response program for specific definitions and practice guidelines related to response paths. The path of response decision is only used in counties with a differential response program.

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Appropriate Completion
If a referral was/will be created in CWS/CMS, complete a hotline tool.

STEP I. PRELIMINARY SCREENING

If the referral does not involve a child under 18; is a duplicate referral; is being referred to another county; is limited to alleged harm in a group home, residential treatment facility, or other institution; or concerns a safely surrendered baby, mark the specific reason under "review of screening criteria is not required."

In these cases, the screening decision is complete. Step II, Appropriateness of a Child Abuse/Neglect Report for Response; Step III, Response Priority; and Step IV, Path of Response Decision are not required.

Record the specific reasons in CWS/CMS.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

A. Screening Criteria

Based on the caller's concerns, mark all criteria that apply. Do not mark items if the caller's information does not reach the threshold of the definition for an item.

B. Screening Decision

Indicate the screening decision. If one or more criteria are marked, the referral is assigned for an in-person CWS response (proceed to Step III). If no criteria are marked, the referral will be evaluated out (for differential response counties, go to Step IV, Path of Response Decision, then A, Path Decision for Evaluate Out; all others require no further action).

Overrides
If an override is used to assign a referral for in-person response when no screening criteria are marked in Step II, Section A, no further SDM assessments are required.

STEP III. RESPONSE PRIORITY

A. Decision Trees

- Allegation concerns maltreatment by current substitute care provider AND county policy requires response within 24 hours (automatic 24-hour). Mark if the child is in out-of-home care and the allegations concern the substitute care provider AND county policy requires a response within 24 hours, making the referral an automatic 24-hour response. If not applicable, proceed to the decision trees.

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- Child is already in custody (automatic 24-hour). If a child has already been taken into protective custody, the referral will be an automatic 24-hour response. Workers in differential response counties should proceed to Step IV, Path of Response Decision.

Select the response priority decision tree that corresponds with the allegation type (physical abuse, emotional abuse, neglect, or sexual abuse). If there is more than one allegation, begin with the most serious allegation. Start with the first question, and gather information from the caller that will lead to an answer of yes or no. Be sure to consult definitions. The response will lead to either a decision regarding response time or to another question. Continue to ask as many questions as are required to arrive at a recommended response time.

- Additional allegations. Once a response time of 24 hours is reached, it is not necessary to complete additional decision trees, even if there are other allegations. If the first tree leads to a time of 10 days, complete additional decision trees until all allegations are completed or a 24-hour response time has been determined, whichever comes first.

- Unknown answers. If the reporter's information cannot clearly distinguish between a yes or no response to a question, try asking additional questions, or asking questions in different ways. If it remains unclear, answer in the way that is most protective of the child.

B. Overrides

After completing all required decision trees, proceed to the overrides and determine whether any apply. Consider overrides even if response priority trees have been bypassed based on screening criteria.

- Policy. If 10 days is the presumptive response, consider whether any of the policy overrides to 24 hours apply. If 24 hours is the presumptive response, consider whether any of the policy overrides to reduce response priority by one level apply.

- Discretionary. If the caller reported any information, or information from any other source suggests that the child's safety, permanency, or well-being is best served by a different response time than the presumptive response, mark whether the response time will be increased or decreased. For example, consider the ability to locate child/caregiver and protective capacities. Briefly describe the fact(s) that led to this conclusion. Discuss a discretionary override with a supervisor and obtain approval.

Final Response Priority

Indicate a final response priority.

STEP IV. PATH OF RESPONSE DECISION (differential response counties only)

Based on screening criteria, complete either Path Decision for Evaluate Out OR Path Decision for In-Person Response.

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A. Path Decision for Evaluate Out
If the county has a differential response system, all referrals that were evaluated out will be considered for Path 1 assignment. Mark any applicable items listed that were present at the time of the referral based on reported information. Record the path decision for referrals that did not meet any screening criteria (No Response or Path 1).

B. Path Decision for In-Person Response
If the county has a differential response system, all referrals that are assigned for in-person response should be forwarded to the differential response coordinator. If the response priority decision is within 24 hours, the worker may bypass the criteria and mark "yes" for automatic Path 3 response. The criteria that resulted in the 24-hour response time would often also result in a Path 3 decision. Alternatively, the worker may review the criteria and base the path decision on the criteria.

Note: The following guidelines were developed in consultation with several SDM® counties to provide recommendations for a consistent process to document subsequent referrals received for the same incident/allegation, or referrals of new information received prior to the first face-to-face contact. Some counties may use different CWS/CMS documentation practices to record these types of referrals. Whatever the county's method, ensure that these referral types are appropriately identified/coded so that it is clear that additional SDM assessments are not required.

1. Secondary referrals. If, after gathering all information from the reporter, it is apparent that all of the allegations made by the reporter are identical to allegations made in an existing open referral, the worker should create a second referral in CWS/CMS and mark it accordingly. This second referral may contain an additional description of the family/events but should not contain a new incident or allegation. No new hotline tool is required for a secondary referral. (If the second call contains information that would change screening, response priority, or path decision, that is an indicator that it is NOT a secondary referral.)

2. Associated referrals. If a second or subsequent call is received that does contain new information, but the worker has not yet made a first face-to-face contact with the family, the referrals should be combined in CWS/CMS as an associated referral. The hotline worker should complete a new hotline tool to determine whether the response should change. However, the investigating worker will complete only one safety and risk assessment that will be linked to all associated referrals. If the second call is received AFTER an initial safety assessment was completed but BEFORE a risk assessment was completed, the worker should associate the referrals in CWS/CMS. In webSDM, complete the risk assessment in the first referral. With rare exceptions, a second safety assessment should be added to the first referral based on changing circumstances.

3. Changing decisions. Prior to worker contact with the family, it is possible that additional information will lead to different answers to the various components of the hotline tool. Retain the original completed tool to show what decision was made and the basis for that decision. In webSDM, open the FIELD UPDATE option and indicate the NEW decision. Provide a brief explanation of the basis for the change. THE

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CHANGE MUST BE CONSISTENT WITH DECISION CRITERIA, OR AN APPROPRIATE OVERRIDE REASON SHOULD BE STATED.

Practice Considerations

Workers will make every effort to elicit information from the reporter to make the key hotline decisions of whether to initiate an in-person response, how quickly to respond, and the path of response. To the extent time allows and if the reporter has additional information, the worker should also elicit information regarding the reporter's knowledge of family strengths, use of services, and the reporter's perspective on family needs.

In all calls, workers will gather as much identifying information as the reporter has available, information on the family's language, cultural identity, current location of child and ability to locate, and issues that have an impact on the safety of responding workers (e.g., weapons, propensity to violence, dangerous animals).

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CALIFORNIA
SDM® SAFETY ASSESSMENT

Referral Name: _____ **Referral #:** _____

County: _____ **Worker:** _____

Is either caregiver Native American or a person with Indian ancestry? ☐ Yes ☐ No ☐ Parent Not Available ☐ Parent Unsure

Date of Assessment: _____/_____/_____ **Assessment Type:** ☐ Initial ☐ Review/update ☐ Referral closing/case closing

Names of Children Assessed: (If more than six children are assessed, add additional names and numbers on reverse side.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are there additional names on reverse? ☐ 1. Yes ☐ 2. No

Household Name: _____ **Were there allegations in this household?** ☐ 1. Yes ☐ 2. No

Factors Influencing Child Vulnerability (Conditions resulting in child's inability to protect self; mark all that apply to <u>any</u> child.)

☐ Age 0–5 years
☐ Significant diagnosed medical or mental disorder
☐ Not readily accessible to community oversight
☐ Diminished mental capacity (e.g., developmental delay, nonverbal)
☐ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)

SECTION 1: SAFETY THREATS

Assess household for each of the following safety threats. Indicate whether currently available information results in reason to believe a safety threat is present. Mark all that apply.

Yes	No		
☐	☐	1.	Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by: ☐ Serious injury or abuse to the child other than accidental. ☐ Caregiver fears he/she will maltreat the child. ☐ Threat to cause harm or retaliate against the child. ☐ Domestic violence likely to injure child. ☐ Excessive discipline or physical force. ☐ Drug-/alcohol-exposed infant.
☐	☐	2.	Child sexual abuse is suspected, AND circumstances suggest that the child's safety may be of immediate concern.
☐	☐	3.	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
☐	☐	4.	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
☐	☐	5.	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in severe psychological/emotional harm AND these actions result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
☐	☐	6.	Caregiver is unable OR unwilling to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.
☐	☐	7.	Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, AND the nature of the injury suggests that the child's safety may be of immediate concern.
☐	☐	8.	The family refuses access to the child, or there is reason to believe that the family is about to flee.

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☐ ☐ 9. Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.

☐ ☐ 10. Other (specify): _____

Safety Decision: If no safety threats are present, complete the safety decision below.

☐ 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. Complete the investigation and the risk assessment as required.

SECTION 1A: CAREGIVER COMPLICATING BEHAVIORS

If any safety threats above are marked yes, indicate whether any of the following behaviors are present. These are conditions that make it more difficult or complicated to create safety for a child but do not by themselves create a safety threat. These behaviors must be considered when assessing for and planning to mitigate safety threats with a safety plan. Mark all that apply to the household.

☐ Substance abuse ☐ Domestic violence ☐ Mental health ☐ Developmental/cognitive impairment
☐ Physical condition ☐ Other (specify): _____

SECTION 2: HOUSEHOLD STRENGTHS AND PROTECTIVE ACTIONS

Household Strengths: These are resources and conditions that increase the likelihood or ability to create safety for a child but in and of themselves do not fully address the safety threats.

Protective Actions: These are specific actions, taken by one of the child's current caregivers or by the child, that mitigate identified safety threats in the household.

Household strengths and protective actions should be assessed, considered, and built upon when creating a safety plan. *Mark all that apply to the household.*

	Household Strengths (***Mark all that apply***)	**Protective Actions** (***Mark all that apply***)
Caregiver problem solving	☐ At least one caregiver identifies and acknowledges the problem/safety threat(s) and suggests possible solutions.	☐ At least one caregiver articulates specific strategies that, in the past, have been at least partially successful in mitigating the identified safety threat(s), and the caregiver has used or could use these strategies in the current situation.
Caregiver support network	☐ At least one caregiver has at least one supportive relationship with someone who is willing to be a part of his/her support network. ☐ At least one non-offending caregiver exists and is willing and able to protect the child from future harm. ☐ At least one caregiver is willing to work with the agency to mitigate safety threats, including allowing the caseworker(s) access to the child.	☐ At least one caregiver has a stable support network that is aware of the safety threat(s), has been or is responding to the threat(s), and is willing to provide protection for the child.
Child problem solving	☐ At least one child is emotionally/ intellectually capable of acting to protect him/herself from a safety threat.	☐ At least one child, in the past or currently, acts in ways that protect him/herself from a safety threat(s).
Child support network	☐ At least one child is aware of his/her support network members and knows how to contact these individuals when needed.	☐ At least one child has successfully pursued support, in the past or currently, from a member of his/her support network, and that person(s) was able to help address the safety threat and keep the child safe.
Other	☐ Other	☐ Other

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SECTION 3: IN-HOME PROTECTIVE INTERVENTIONS

If safety threats have been identified in the household and after consideration of child vulnerabilities, household strengths, and protective actions, it is determined that a safety plan will allow the child to remain in the home, the safety decision is "safe with plan." Mark the decision below. If a safety plan that would allow the child to remain in the home safely cannot be created, go to Section 4.

Safety Decision

☐ Safe with plan. One or more safety threats are present; however, the child can safely remain in home with a safety plan. In-home protective interventions have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Mark all in-home interventions used in the safety plan.

- ☐ 1. Intervention or direct services by worker. (DO NOT include the investigation itself.)
- ☐ 2. Use of family, neighbors, or other individuals in the community as safety resources.
- ☐ 3. Use of community agencies or services as safety resources.
- ☐ 4. Use of tribal, Indian community service agency, and/or ICWA program resources.
- ☐ 5. Have the caregiver appropriately protect the victim from the alleged perpetrator.
- ☐ 6. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
- ☐ 7. Have the non-offending caregiver move to a safe environment with the child.
- ☐ 8. Legal action planned or initiated—child remains in the home.
- ☐ 9. Other (specify): _____

SECTION 4: PLACEMENT INTERVENTIONS

Safety Decision

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

- ☐ 10. Have the caregiver voluntarily place the child outside the home, consistent with WIC § 11400 (o) and (p).
- ☐ 11. Child placed in protective custody because interventions 1–10 do not adequately ensure the child's safety.

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CALIFORNIA
SDM® SAFETY ASSESSMENT
DEFINITIONS

Factors Influencing Child Vulnerability (conditions resulting in child's inability to protect self; mark all that apply to any child in the household)

- Age 0–5 years. Any child in the household is under the age of 5. Younger children are considered more vulnerable, as they are less verbal and less able to protect themselves from harm. Younger children also have less capacity to retain memory of events. Infants are particularly vulnerable, as they are nonverbal and completely dependent on others for care and protection.

- Significant diagnosed medical or mental disorder. Any child in the household has a diagnosed medical or mental disorder that significantly impairs ability to protect him/herself from harm, OR diagnosis may not yet be confirmed but preliminary indications are present and testing/evaluation is in process. Examples may include but are not limited to: severe asthma, severe depression, medically fragile (e.g., requires assistive devices to sustain life), etc.

- Not readily accessible to community oversight. The child is isolated or less visible within the community (e.g., the family lives in an isolated community, the child may not attend a public or private school or be routinely involved in other activities within the community, etc.).

- Diminished developmental/cognitive capacity. Any child in the household has diminished developmental/cognitive capacity, which impacts ability to communicate verbally or to care for and protect self from harm.

- Diminished physical capacity (e.g., non-ambulatory, limited use of limbs). Any child in the household has a physical condition/disability that impacts ability to protect self from harm (e.g., cannot run away or defend self, cannot get out of the house in an emergency situation if left unattended).

SECTION 1: SAFETY THREATS

1. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by:

- Serious injury or abuse to the child other than accidental. The caregiver caused, or could have caused a serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, or severe cuts, and the child requires medical treatment.

  Caregiver fears he/she will maltreat the child. The caregiver has reported credible fears that he/she will hurt the child in a way that would cause serious injury and/or requests placement.

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- 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 child protective services (CPS) investigation.

- Domestic violence likely to injure child. There have been incidents of household violence that created danger of serious physical injury to the child AND there is reason to believe that this may occur again (e.g., alleged domestic violence perpetrator and victim are still involved in relationship; a pattern of household violence continues to exist). For example:

  » Child was in the arms of one person during a violent episode;

  » A gun, knife, or other implement was involved;

  » Child attempted to intervene or was near enough to the violent altercation that he/she was in harm's way; or

  » Child was previously injured in a domestic/family violence incident (e.g., fractures, bruising, cuts, or burns) and there is violence occurring now.

- Excessive discipline or physical force. The caregiver used physical methods to discipline a child that resulted or could easily result in serious injury, OR caregiver injured or nearly injured a child by using physical force for reasons other than discipline.

- Drug/alcohol-exposed infant. There is evidence that the mother used alcohol or other drugs 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.

  » Indicators of imminent danger include: the level of toxicity and/or type of drug present, the infant is diagnosed as medically fragile as a result of drug exposure, or the infant suffers adverse effects from introduction of drugs during pregnancy.

2. Child sexual abuse is suspected, AND circumstances suggest that the child's safety may be of immediate concern.

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

- The child discloses sexual abuse verbally.

- The child displays behaviors that strongly indicate sexual abuse (e.g., excessive, age-inappropriate sexualized behavior toward self or others).

- Medical findings consistent with molestation.

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

- The caregiver or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing the child to observe sexual performances or activities, or commercial sexual exploitation, including sex trafficking).

  » Children and youth aged 17 years old and younger are sexually exploited when they have engaged in, solicited for, or been forced to engage in sexual conduct or performance of sexual acts (e.g., stripping) in return for a benefit, such as money, food, drugs, shelter, clothing, gifts, or other goods, or for financial or some other gain for a third party. The sexual conduct may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed.

  » Commercial sexual exploitation of children/youth/young adults may include prostitution, pornography, trafficking for sexual purposes, and other forms of sexual exploitation. The youth is treated as a sexual object and as a commercial object. The sexual exploitation of the child may profit a much wider range of people than the immediate beneficiary of the transaction.

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

- There is not a non-offending caregiver, or the non-offending caregiver is not protective (blaming the child for the sexual abuse or the investigation or denying that the sexual abuse occurred) or is otherwise influencing or coercing the child victim regarding disclosure.

- Access to a child by a confirmed sexual abuse perpetrator, especially with known restrictions regarding any child under age 18, exists.

3. Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.

The caregiver is unable or unwilling to address critical areas of food, clothing, shelter, supervision, and/or medical and mental health care for the child AND the child has been seriously harmed or is in imminent danger of being seriously harmed as a result.

- The child's nutritional needs are not met, resulting in danger to the child's health and/or safety, including malnutrition and morbid obesity.

- The child is without clothing appropriate to the weather. Consider the age of the child and whether clothing is the choice of the child or has been provided by the caregiver.

- The caregiver does not seek treatment for the child's immediate, chronic, and/or dangerous medical condition(s), or does not follow prescribed treatment for such conditions, resulting in declining health status (e.g., not providing insulin for a child

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with diabetes, not providing follow-up care for a wound that is infected, or not providing care for a broken bone).

Note: The pursuit of traditional or alternative practices rather than prescribed treatment is included here IF there is evidence that the child's health status is declining AND there is evidence that prescribed treatment would likely be effective.

- The child has exceptional needs, such as being medically fragile, which the caregiver does not or cannot meet, resulting in declining health status.

  The child is suicidal and/or is seriously self-harming AND the caregiver will not/cannot take protective action.

- The child shows effects of maltreatment, such as serious emotional symptoms, lack of behavioral control, or serious physical symptoms. This may include situations where a child exhibits severe anxiety (e.g., nightmares, insomnia, exhibits fear) related to situations associated with domestic violence.

- The caregiver is present but does not attend to the child to the extent that need for care goes unnoticed or unmet (e.g., can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).

- The caregiver leaves the child alone (time period varies with age and developmental stage) in circumstances that create opportunities for serious harm, e.g., child left unattended in vehicle.

- The caregiver is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) and there are no arrangements for the child that would ensure his/her safety.

- The caregiver makes inadequate and/or inappropriate babysitting or child care arrangements, or demonstrates very poor planning for the child's care during absences, and these arrangements do not provide minimal safety for the child (e.g., temporary caregiver is intoxicated, has limited capacity, or for any reason is unable to meet child's needs).

4. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:

- Leaking gas from stove or heating unit.

- Lack of water or utilities (heat, plumbing, electricity), and no alternative or safe provisions have been made.

- Open/broken/missing windows.

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- Exposed electrical wires.
- Excessive garbage or rotted or 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 and other weapons are not locked and not properly secured.
- Drug production in the home.
- Substances (including drugs, drug paraphernalia or cleaning supplies) or objects within reach of child that may endanger his/her health and/or safety.

5. **Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in severe psychological/emotional harm AND these actions result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.**
   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 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 for family problems.
   - The caregiver places the child in the middle of a custody battle.

6. **Caregiver is unable OR unwilling to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.**
   The caregiver fails 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 or sexual abuse resides in the home, or the caregiver allows access to the child. Include regardless of whether the caregiver (1) knew of the history and allowed access, or (2) upon learning of the history, has not prevented further access.

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- The caregiver regularly takes the child to dangerous locations where drugs are manufactured or regularly administered (e.g., meth labs or drug houses), or locations used for prostitution or pornography.

- In circumstances of domestic violence, the non-offending caregiver is not able to protect him/herself or the child from immediate threat of physical and emotional harm.

7. Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, AND the nature of the injury suggests that the child's safety may be of immediate concern.

Factors to consider include the child's age, location of injury, exceptional needs of the child, or chronicity of injuries.

- The injury requires medical attention AND medical assessment indicates the injury is likely to be the result of abuse or is inconsistent with the explanation provided by the caregiver; OR

- There was a suspicious injury that did not require medical treatment but covered multiple parts of the body, appeared to be caused by an object, or is in different stages of healing, AND/OR was located on an infant, or for older children, on the torso, face, or head.

AND one of the following is true:

- The caregiver denies abuse or attributes the injury to accidental causes; OR

- The caregiver's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury; OR

- The caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child.

8. The family refuses access to the child, or there is reason to believe that the family is about to flee.

This safety threat should only be identified when other threats are near, but do not reach the threshold in the definitions; the worker has made attempts to contact the child and been refused access by the caregiver; OR there is reason to believe the family is about to flee during an ongoing investigation after an initial safety assessment has been completed.

- The family currently refuses access to the child or cannot/will not provide the child's location.

- The family has removed the child from a hospital against medical advice to avoid investigation.

- The family has previously fled in response to a CPS investigation or there is credible information that the family is about to flee.

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

9. **Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.**
There must be both current, immediate threats to child safety AND related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.

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 or bone fracture, subdural hemorrhage or 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 could have caused severe injury, there was retaliation or threatened retaliation against a child for previous incidents, or prior domestic violence resulted in serious harm or threatened harm to a child.

- Prior service failure. Failure to successfully complete court-ordered or voluntary services.

10. **Other (specify).** Circumstances or conditions that pose an immediate threat of serious harm to a child, which are not already described in safety threats 1–9.

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Safety Decision

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. Complete the investigation and the risk assessment as required.

SECTION 1A: CAREGIVER COMPLICATING BEHAVIORS

Substance abuse. : Caregiver has abused legal or illegal substances or alcoholic beverages in this incident to the extent that control of his/her actions or ***caregiving*** abilities is significantly impaired, or information is available that ***past abuse of legal or illegal substances has impaired the parent's caregiving capabilities in the past***.

Domestic violence. There are indications of a recent history of one or more physical assaults between intimate members of the household, or threats/intimidation or harassment that are known as a result of self-report or other credible report by a family or other household member, friend, other collateral contacts, and/or police reports.

Mental health. One or both caregivers appear to be mentally ill at the time of this incident or have a known history of mental health issues ***that have or could have impacted care of children***.

Developmental/cognitive impairment. One or both caregivers may have diminished capacity as a result of developmental delays or cognitive issues ***that may impact their ability to provide care and supervision of children***.

Physical condition. One or both caregivers has a physical condition that impacts care and protection of the child in the household.

SECTION 2: HOUSEHOLD STRENGTHS AND PROTECTIVE ACTIONS

Household strengths are resources and coping skills/qualities in an individual or a family that contribute in positive ways to family life but do not, in and of themselves, directly enhance the child's protection from the safety threat(s) over time. These characteristics can be built upon for future planning and indicate the capability to be used in the safety planning process.

Protective actions are specific actions and/or activities that have been taken by the caregiver that directly address the safety threat and are demonstrated over time. These are observed activities that have been demonstrated in the past and can be directly incorporated into the safety plan for the family and child. They may also include actions taken by the child in some circumstances. Actions taken by the child should not be the basis for the safety plan but may be incorporated as part of the plan.

Household Strengths

The following strengths should be assessed, considered, and built upon when creating a safety plan to mitigate the safety threats. Mark all that apply to the household.

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At least one caregiver identifies and acknowledges the problem/safety threat(s) and suggests possible solutions. The caregiver demonstrates an understanding of the issues that led to the current safety threats and participates in planning to mitigate the situation by suggesting possible solutions for mitigating the safety threat.

At least one caregiver has at least one supportive relationship with someone who is willing to be a part of his/her support network. The caregiver has a supportive relationship with at least one other family member, neighbor, or friend who may be able to assist in safety planning. This support network member is someone who cares about the child or family but may not, at this time, know what the safety threat is, or has not yet been asked to take action to ensure that the child is protected from those threats now and into the future.

At least one non-offending caregiver exists and is willing and able to protect the child from future harm. There is at least one caregiver who has done nothing to contribute to the existence of the safety threat. This 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 may be willing to become part of a support network and protect the child going forward.

At least one caregiver is willing to work with the agency to mitigate safety threats, including allowing caseworker(s) access to the child. In the current investigation or assessment, the caregiver allows CPS to have contact with the child for the purpose of assessing child safety. This includes interviews and observation of children in the household. The caregiver accepts the involvement and initial service recommendations of the worker or other individuals working through referred community agencies, including tribal or Indian community service agencies, and/or the use of ICWA program resources. 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 intervention.

At least one child is emotionally/intellectually capable of acting to protect him/herself from a safety threat. At least one child has the intellectual or emotional capacity to ask for help. He/she understands his/her 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).

At least one child is aware of his/her support network members and knows how to contact these individuals when needed. When faced with a potentially dangerous situation, at least one child can currently name adults who care about him/her and who would be able to help him/her in the future. Child also has strategies for how to reach the adults.

Other. Other qualitative actions, resources, and coping demonstrated by the caregiver or family that could be built upon in a safety plan but do not, by themselves, fully address the safety threat.

Protective Actions

The following actions should be assessed, considered, and built upon when creating a safety plan. Mark all that apply to the household.

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At least one caregiver articulates specific strategies that, in the past, have been at least partially successful in mitigating the identified safety threat(s), and the caregiver has used or could use these strategies in the current situation. At least one caregiver in the household has been able to protect the child from similar threats in the past through his/her own actions or by using resources. The caregiver is able to describe both the current threats and the strategies he/she is using to mitigate them currently.

At least one caregiver has a stable support network that is aware of the safety threats(s), has been or is responding to the threat(s), and is willing to provide protection for the child. A caregiver regularly interacts, communicates and makes plans with an extended network of family; friends; neighbors; and/or cultural, religious, or other communities that provide support and meet a wide range of needs for the caregiver and/or the child (including tribal ICWA programs, Indian organizations, and/or family members, which can include non-related tribal members). The caregiver has informed these network members of the threats and they have assisted in the situation by providing protection to the child (e.g., members of the support network have provided food when needed, assistance to prevent utility shut-off, or a planned safe place for the child to stay in the event of violence in the household; not allowing an offending caregiver to have unplanned forms of contact, etc.).

At least one child, in the past or currently, acts in ways that protect him/herself from a safety threat(s). Prior to the current threat, in response to similar circumstances where a threat has been present or circumstances leading to a threat were escalating, the child has been able to protect him/herself. For example, the child was able to remove him/herself from the situation, called 911 to seek assistance, or was able to find another way to mitigate the safety threat.

At least one child has successfully pursued support, in the past or currently, from a member of his/her support network, and that person(s) was able to help address the safety threat and keep the child safe. When faced with one of the safety threats, the child was able to seek help from and receive the necessary assistance from someone in the identified support network (e.g., family members, friends, professionals) AND can currently name adults who care about him/her and would be able to help if a similar situation arose in the future.

Other. Other actions of protection taken by the caregiver, a household member, safety network member, and/or the child, which mitigate one or more of the safety threats.

SECTION 3: IN-HOME PROTECTIVE INTERVENTIONS

Safety Decision

Safe with plan. One or more safety threats are present; however, the child can safely remain in home with a safety plan. In-home protective interventions have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Mark all in-home interventions used in the safety plan.

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes. Follow county policies whenever applying any of the safety interventions.

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1. **Intervention or direct services by worker. (DO NOT include the investigation itself.)**
Actions taken or planned by the investigating worker or other CPS staff that specifically address one or more safety threats. Examples include: providing information about nonviolent 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 restraining orders; and providing definitions of child abuse laws and informing involved parties of the consequences of violating these laws. DOES NOT INCLUDE the investigation itself or services provided to respond to family needs that do not directly affect safety.

2. **Use of family, neighbors, or other individuals in the community as safety resources.**
This includes applying the family's own strengths as resources to mitigate safety concerns or using extended family members, neighbors, or other individuals to mitigate safety concerns. Examples include: family's agreement to use nonviolent means of discipline; 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 12-step sponsor to meet with the caregiver daily and call the worker if the caregiver has used or missed a meeting;

   OR

   The caregiver's decision, *as part of a safety plan*, to have the child cared for by a friend or relative for a limited period of time, such as overnight or for a few days.

3. **Use of community agencies or services as safety resources.**
Involving a community-based or faith-related organization or other agency in activities to address immediate safety threats (e.g., using a local food pantry). DOES NOT INCLUDE long-term therapy or treatment, or being put on a waiting list for services.

4. **Use of tribal, Indian community service agency, and/or ICWA program resources.**
This includes but is not limited to:

   - Use of tribal family services from the child's/caregiver's tribe or a tribal consortium;
   - Indian resource centers;
   - Indian health clinics;
   - Tribal TANF (Temporary Assistance for Needy Families);
   - Title VII Indian education programs, which may not be affiliated with a tribe; and
   - A county-based dedicated Indian specialist or service unit.

5. **Have the caregiver appropriately protect the victim from the alleged perpetrator.**
A non-offending caregiver has acknowledged the safety threats and is able and willing to protect the child from the alleged perpetrator. A non-offending caregiver who had prior knowledge of the alleged perpetrator's actions but took no action prior to the safety assessment should not be the only safety resource or intervention. Examples include agreement that the child will not be alone with the alleged perpetrator or agreement that the caregiver will restrain the alleged perpetrator from physical discipline of the child.

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6. **Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.**
   Temporary or permanent removal of the alleged perpetrator. Examples include: arrest of alleged perpetrator, non-perpetrating caregiver "kicking out" alleged perpetrator who has no legal right to the residence, or the alleged perpetrator agrees to leave.

7. **Have the non-offending caregiver move to a safe environment with the child.**
   A caregiver not suspected of harming the child has taken or plans to take the child to an alternative location where the alleged perpetrator will not have access to the child. Examples include a domestic violence shelter, home of a friend or relative, or hotel.

8. **Legal action planned or initiated—child remains in the home.**
   Legal action has already commenced, or will be commenced, that will immediately and effectively mitigate identified safety threats and is identified in the safety plan. This includes family-initiated actions (e.g., restraining orders, mental health commitments, change in custody/visitation/guardianship) and CPS-initiated actions (file petition and child remains in the home). This includes actions taken by the child's tribe and tribal court to intervene or take jurisdiction of the Indian child's case.

9. **Other (specify).**
   The family or worker identifies a unique intervention for an identified safety concern that does not fit within items 1–8.

SECTION 4: PLACEMENT INTERVENTIONS

Safety Decision

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

10. **Have the caregiver voluntarily place the child outside the home, consistent with WIC § 11400 (o) and (p).**
    A voluntary agreement is signed between the caregiver and the CPS agency to place the child in an approved resource family placement, tribally approved home, or tribally specified home, and the caregiver is cooperating with the agency to provide needed consents and information to fund this voluntary placement. This voluntary agreement is consistent with Welfare and Institutions Code (WIC) § 11400 (o) and (p). The caregiver understands that if he/she withdraws consent for voluntary placement and identified safety threats are still present, other interventions to ensure the child's safety will need to be considered.

11. **Child placed in protective custody because interventions 1–10 do not adequately ensure the child's safety.**
    One or more children are protectively placed pursuant to WIC § 309 and are entitled to notice and a hearing within 72 judicial hours.

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CALIFORNIA
SDM® SAFETY ASSESSMENT
POLICY AND PROCEDURES

The purpose of the safety assessment is: (1) to help assess whether any child is likely to be in immediate danger of serious harm/maltreatment, which requires a protective intervention, and (2) to determine what interventions should be initiated or maintained to provide appropriate protection.

Safety versus risk assessment: It is important to keep in mind the difference between safety and risk when completing this form. Safety assessment differs from risk assessment in that it assesses the child's present danger of immediate/serious harm and the interventions currently needed to protect the child. In contrast, risk assessment looks at the likelihood of any future maltreatment.

Which Cases: All referrals that are assigned for in-person response.

If referral alleges maltreatment by a substitute care provider, use the substitute care provider safety assessment (page 55 of this manual).

Any open referrals or cases in which changing circumstances require safety assessment due to:

- Change in family circumstances;
- Change in information known about the family; or
- Change in the ability of safety interventions to mitigate safety threats.

Who: The social worker who is responding to the referral.

When: For a new referral, the safety assessment *process* is completed, using the safety assessment field guide, before leaving a child in the home, or returning a child to the home during the investigation, following the initial face-to-face contact with all child victims. The safety assessment form should be completed within two working days of the first contact.

- For a child who has already been protectively placed by law enforcement or other means, and for whom no safety assessment has been completed, the social worker will complete a safety assessment within two working days of the referral.

- For open referrals or cases in which changing circumstances prompt a new safety assessment, the safety assessment *process* is completed immediately. The safety assessment *form* is completed within two working days.

- If a safety plan was initiated, there must be an updated safety assessment documenting that the safety threats have been resolved. If safety threats remain unresolved, a case should be opened.*

*If the child is no longer living in the household that has unresolved safety threats, and that parent refuses services, the case may be closed.

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- A safety assessment must be done prior to closing a case. A case will not be closed if safety threats in the household are present.

Decision: The safety assessment provides structured information concerning the danger of immediate/serious harm/maltreatment to a child. This information guides the decision about whether the child may remain in the home with no intervention (safe), may remain in the home with safety interventions in place (safe with plan), or must be protectively placed (unsafe).

Appropriate Completion

Workers should familiarize themselves with the items that are included on the safety assessment and the accompanying definitions. Workers will notice that the items on the tool are items they are probably already assessing. What distinguishes SDM is that it ensures that every worker is assessing the same items in each case, and that the responses to these items lead to specific decisions. Once a worker is familiar with the items that must be assessed to complete the tool, the worker should conduct his/her initial contact as he/she normally would—using good social work practice to collect information from the child, caregiver, and/or collateral sources. SDM ensures that the specific items that comprise the safety assessment are assessed at some time during the initial contact.

The decision logic for the safety assessment is:

- If no safety threats are marked, the only possible safety decision is "Safe: No safety threats were identified at this time." No in-home interventions or placement interventions need to be reviewed; the assessment is complete.

- If one or more safety threats are marked, the worker must determine whether an in-home safety plan will mitigate the safety threat or whether the child must be placed.

- If a safety plan can be developed with the caregivers, only interventions 1 through 9 can be marked and the safety decision is "Safe with Plan: One or more safety threats are present; however, the child can safely remain in home with a safety plan." In-home protective interventions have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Placement (interventions 10 and 11) should not be marked as an intervention if other interventions are marked.

- If a safety plan cannot be developed with the caregivers, then placement intervention 10 or 11 must be marked and the safety decision must be "Unsafe: One or more safety threats are present, and placement is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm."

Complete all assessment header information as indicated:

- Record the date of the safety assessment. The date of assessment is typically the date that the worker made initial face-to-face contact with the child to assess safety, which may be different than the date that the form is completed in webSDM.

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- Indicate whether the either caregiver is either a Native American or a person with Indian Ancestry. When working with a family, WIC §224.3(a) requires the worker to inquire whether a child is or may be an Indian child. If a caregiver or other reliable source in the household states that they are Native American, answer yes. If a caregiver states that they are not Native American, answer No. If the caregiver is not available (incarcerated, hospitalized, unable to locate, etc.) answer parent not available and follow county procedures to identify and record in CWSCMS. If a parent has been asked and is unsure but will inquire further, follow county procedures to identify and record in CWSCMS.

- Enter the type of safety assessment, which is either:

  » **Initial.** Each referral should have one initial assessment, completed during the first face-to-face contact with at least one child victim in the household where there are allegations. However, if there are allegations in two households within a single referral, there may be two initial safety assessments.

  » **Review/update.** After the initial assessment, any additional safety assessment is most likely a review/update, unless it is completed at the point of closing a referral or case. A review/update includes a safety assessment completed on a second household where there are no allegations.

  » **Referral closing.** This is a specialized review/update that is completed when considering closing a referral without promoting it to a case when a safety threat has been documented at some point during the investigation. This option only appears in webSDM when completing a safety assessment on a referral.

  » **Case closing.** This is a specialized review/update that is completed when considering closing a case. This option only appears in webSDM when completing a safety reassessment on an open ongoing case.

- Enter the name of the household assessed. In referrals where there is more than one household, and there are allegations regarding each household, a safety assessment is required on both. Enter the name of the household assessed.

  » Also mark whether there are allegations in the household being assessed. If at least one alleged perpetrator resides in the household, there are allegations in that household.

  » If the household is being assessed for safety as a potential placement (e.g., a non-custodial parent), mark "no."

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

The safety assessment consists of five sections:

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SECTION1: SAFETY THREATS

This is a list of 10 critical threats (nine identified and defined and an "other") that must be assessed by every worker in every case. These threats cover the kinds of conditions that, if they exist, would render a child in danger of immediate, serious harm.

For this section, rely on information available at the time of the assessment. Workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is expected that not all facts about a case can be known immediately. Some information is inaccessible, and some is deliberately hidden from the worker. 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 that item "no." Because not every conceivable safety threat can be anticipated or listed on a form, the "other" category permits a worker to indicate that some other circumstance creates a safety threat. 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 "other" and briefly describe the threat.

Safety Decision: If there are no identified safety threats in the household, the safety decision is "safe." Mark "Safe" and the safety assessment is completed.

SECTION 1A: CAREGIVER COMPLICATING BEHAVIORS

This section is completed only when there are safety threats identified as present in the household. If any of the safety threats were marked "yes" and there is evidence that one or more caregivers are experiencing substance abuse, mental health concerns, domestic violence, or cognitive/developmental or physical health concerns, indicate all that apply. These are conditions which make it more difficult or complicated to create safety for a child, but do not by themselves constitute a safety threat. These behaviors must be considered when assessing for and planning to mitigate safety threats. Mark all that apply to the household. Additionally, when completing the subsequent risk assessment and the family strengths and needs assessment, be attentive to these concerns.

SECTION 2: HOUSEHOLD STRENGTHS AND PROTECTIVE ACTIONS

This section is completed only if one or more safety threats were identified. Mark any of the listed protective capacities that are present for any child/caregiver. Consider information from the referral; from worker observations; interviews with children, caregivers, and collaterals; and review of records. For "other," consider any existing condition that does not fit within one of the listed categories but may support protective interventions for the safety threats identified in Section 1.

SECTION 3: IN-HOME PROTECTIVE INTERVENTIONS

This section is completed only if one or more safety threats are identified and the worker has determined that a safety plan can be developed with the family that will protect the child in his or her home while the investigation continues. If one or more safety threats are present, it does not automatically follow that a child must be placed. In many cases, it will be possible to initiate a temporary plan that will mitigate the safety threat(s) sufficiently so that the child may remain in the

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home while the investigation continues. When determining whether a safety plan can be developed, consider the relative severity of the safety threat(s), any complicating behaviors by the caregiver that may impact safety planning, household strengths and protective actions, the vulnerability of the child, and the in-home safety interventions that are available.

The in-home protective intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential category of interventions and determine whether an intervention in that category is available and sufficient to mitigate the safety threat(s), and 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 while any single intervention may be insufficient to mitigate the safety threat(s), a combination of interventions may provide adequate safety.

Also keep in mind that the safety intervention is not the case plan—it is not intended to "solve" the household's problems or provide long-term answers. A safety plan permits a child to remain home during the course of the investigation by listing specific, timely actions that address the identified safety threats.

If one or more interventions will be implemented, mark each category that will be used. If there is an intervention that will be implemented that does not fit in one of the categories, mark line 9 and briefly describe the intervention. Safety interventions 10 and 11 are used only when a child is unsafe and only a placement can ensure safety.

Safety Plan

Individual counties should use their own safety plan form. The following must be included in any safety plan:

- Each safety threat that has been identified and a description of the conditions or behaviors in the home that place any child at imminent threat of serious harm. The worker should use language the family understands so it is clear to them what caused the worker to identify the threat.

- Detailed information for each planned safety intervention: What needs to happen to keep the child safe? Explain how safety threat(s) will be mitigated. What will the family do to keep the child safe? What will other people outside the family do? This should include a written statement of actions or behaviors, to be taken by a responsible party, that will keep the child safe in the current conditions.

- Who is participating in the plan, the role of each participant, and information that describes how the safety plan will be monitored (e.g., who is responsible for each intervention action), and the timeframe in which each intervention will remain in place.

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- Signature lines for family members, the worker, and his/her supervisor.

A SAFETY PLAN IS REQUIRED WHEN SAFETY DECISION IS "SAFE WITH PLAN."

Note: The safety plan should be documented in the investigation contact in CWS/CMS.

The safety plan MUST be developed in partnership with and agreed to by the family, and a copy should be left with the family.
If safety threats have not been resolved by the end of the investigation/assessment, the safety plan will be provided to the ongoing worker and all remaining interventions will be incorporated into the ongoing case plan.

SECTION 4: PLACEMENT INTERVENTIONS
This section is only completed when, after considering complicating behaviors that may impact safety planning, household strengths and protective actions, the vulnerability of the child, and the in-home safety interventions that are available, the worker determines that placement is the only intervention for protection of the child.

If one or more safety threats are identified and the worker determines that in-home interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will be placed by selecting placement interventions 10 or 11.

Practice Considerations
While safety is the prevailing concern of the first face-to-face contact, the manner of engaging the family will depend upon social work clinical skills. Whenever possible, the worker should use a strengths-based approach in the initial contact, while remaining observant for the presence or absence of safety threats. Most safety threats are salient and can be discerned without invasive questioning. Others will benefit from candor, which will be more forthcoming when the family is approached with respect. The first face-to-face contact may be limited to assessing safety if there are significant safety issues. At other times, the worker will also begin to gather information regarding risk and/or strengths and needs items, as well as additional clinical information.

For all cases in which the child or caregiver knows their tribe and membership status, the social worker must contact the tribe to engage and team with the designated ICWA agent or tribal family services department.

Resources for American Indian/Alaska Native children vary depending on a tribe's resources and the location of the child and family (rural versus urban, proximity to tribal resources, or proximity to urban Indian community resources). The child's/caregiver's tribe may provide resources through tribal family services or through a tribal consortium. Some urban areas have resources through Indian resource centers, Indian health clinics, Tribal TANF (Temporary Assistance for Needy Families), or Title VII Indian education programs (which may not be affiliated with a tribe). Some counties have a dedicated Indian specialist or specialty unit dedicated to serving Indian children, which can assist with engagement and access to resources. They may also have current contact information to assist the child/caregivers in obtaining official membership with their tribe.

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It is recommended that children and caregivers who know their tribe or have a tribal affiliation contact the tribe (lists of designated ICWA agents are available at the Bureau of Indian Affairs website, bia.gov). Many tribes have public websites that provide information about their ICWA or family service programs.

For children/caregivers who have lost contact with their tribe, are from unrecognized or terminated tribes, or are unsure of their status with a tribe, resources will exist through local Indian resource centers, tribal TANF, or Title VII Indian education programs. Resources are available to assist the social worker and caregivers in tracing Indian ancestry, such as http://www.doi.gov/tribes/trace-ancestry.cfm and http://www.bia.gov/cs/groups/public/documents/text/idc002656.pdf.

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CALIFORNIA
SDM® SUBSTITUTE CARE PROVIDER SAFETY ASSESSMENT

r: 06/15

Primary SCP Name: _____ **Referral #:** _____

SCP Type: ☐ Foster ☐ Relative ☐ NREFM ☐ FFA ☐ Small Family Home

List any other related referrals:

Referral Name	Referral #

Name(s) of foster children in the household:

Name	Age	Name	Age
1.		3.	
2.		4.	

Date of Referral: _____/_____/_____ Date of Assessment: _____/_____/_____
CSW Name: _____

SECTION 1: SAFETY THREATS

Assess the household for each of the following safety threats. Indicate whether currently available information results in reason to believe the safety threat is present for any foster/adoptive child currently residing in the household. Mark all that apply.

☐ 1. The SCP caused physical harm to the child or made a plausible threat to cause physical harm in the current investigation, as indicated by any of the following:
☐ Injury or abuse to the child other than accidental.
☐ The SCP fears he/she will maltreat the child and/or requests the child's removal.
☐ Threat to cause harm or retaliate against the child.
☐ Domestic violence likely to injure child.
☐ Excessive discipline or physical force.

☐ 2. Child sexual abuse is suspected, AND circumstances suggest that the child's safety may be of immediate concern.

☐ 3. The SCP does not meet the child's needs for supervision, food, clothing, and/or medical or mental health care.

☐ 4. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

☐ 5. The SCP routinely describes the child in negative terms or acts towards the child in negative ways.

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☐ 6. The SCP fails to protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, neglect, or emotional abuse.

☐ 7. The SCP's explanation for the injury to the child is questionable or inconsistent with the type of injury.

☐ 8. The SCP hinders/refuses access to the child.

☐ 9. Current circumstances, combined with prior referrals of abuse/neglect and/or incident reports, suggest that the child's safety may be of immediate concern.

☐ 10. Other (specify): _____

_____

Safety Decision: If no safety threats are present, mark the safety decision below.

☐ 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.

SECTION 1A: SUBSTITUTE CARE PROVIDER COMPLICATING BEHAVIORS

If any safety threats are above are marked yes, indicate whether any of the following behaviors are present. These are conditions that make it more difficult or complicated to create safety for a child, but do not by themselves constitute a safety threat. These factors must be considered when assessing for and planning to mitigate safety threats with a safety plan. Mark all that apply to the household.

☐ Substance abuse ☐ Domestic violence ☐ Mental health
☐ Developmental/cognitive impairment ☐ Physical condition

SECTION 2: IN-HOME PROTECTIVE INTERVENTIONS

Safety Decision

☐ Safe with plan. One or more safety threats are present; however, the child can safely remain in the placement with a safety plan. In-home protective interventions have been initiated through a safety plan and the child will remain in the placement as long as the safety interventions mitigate the safety threats. Mark all in-home interventions utilized in the safety plan.

Mark all that apply:
☐ 1. Intervention or direct services by worker.
☐ 2. Use of family, neighbors, or other individuals in the community as safety resources.
☐ 3. Use of community agencies or services as safety resources.
☐ 4. Have the SCP appropriately protect the victim from the alleged perpetrator.
☐ 5. Have the alleged perpetrator leave the household, either voluntarily or in response to legal action.
☐ 6. Other (specify): _____

_____

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SECTION 3: PLACEMENT INTERVENTIONS

☐ 7. Removal from current placement is necessary because interventions 1–6 do not adequately ensure the child's safety.

Safety Decision

☐ Unsafe. One or more safety threats are present, and removal from the SCP's household is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate harm.

Foster Children Removed	Foster Children Not Removed
1.	1.
2.	2.
3.	3.
4.	4.

Caseworker Signature: _____ Date: _____/_____/_____

Supervisor Signature: _____ Date: _____/_____/_____

Copy the appropriate individuals according to agency policy.

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CALIFORNIA
SDM® SUBSTITUTE CARE PROVIDER SAFETY ASSESSMENT
DEFINITIONS

General Definitions

Foster child: Any child for whom the department has legal protective custody, including children for whom adoption is pending and has not yet been finalized.

Legal guardian: A person who has the legal authority and duty to care for a child.

Substitute care provider (SCP): A person providing out-of-home care to children, including approved relatives or non-related extended family members; and licensed foster homes, foster family homes, and/or small family homes.

SECTION 1. SAFETY THREATS

1. The SCP caused physical harm to the child or made a plausible threat to cause physical harm in the current investigation, as indicated by any of the following:

- Any non-accidental injury or abuse to any child in the household.
- The SCP fears he/she will maltreat the child and/or requests the child's removal.
- Threat to cause harm or retaliate against the child. Threat of action which could result in harm; or plans to retaliate against the child for CPS investigation.
- Domestic violence likely to injure child. There have been incidents of household violence that created a danger of physical injury to the child AND there is reason to believe that this may occur again (e.g., domestic violence perpetrator and victim are still involved in a relationship; a pattern of household violence continues to exist). For example:
  - » The child was in the arms of one person during a violent episode.
  - » A gun, knife, or other implement was involved.
  - » The child attempted to intervene or was near enough to violent altercation that he or she was in harm's way.
- Excessive discipline or physical force. The SCP used physical methods to discipline a child that resulted or could easily result in injury; OR the SCP injured or nearly injured a child by using physical force for reasons other than discipline; OR used corporal punishment; or the SCP has acted in a way that bears no resemblance to reasonable discipline.

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2. **Child sexual abuse is suspected and circumstances suggest that the child's safety may be of immediate concern.**
Suspicion of sexual abuse may be based on indicators such as the following:

- The child discloses sexual abuse either verbally or behaviorally by an SCP or others in the household (e.g., age-inappropriate, sexualized behavior toward self or others).
- Medical findings consistent with molestation.
- The SCP or others in household have been convicted, investigated, or accused of sexual misconduct with the child.
- Indications of poorly defined or questionable sexual boundaries between household members; and/or the SCP engages in or permits other household members to engage in behaviors that infringe upon appropriate sexual boundaries. Based on age, gender, and developmental status of household members, examples of inappropriate and/or poorly defined sexual boundaries may include such things as non–gender-specific sleeping arrangements or showering/bathing practices, exposure to nudity or sexually explicit materials, etc.
- Access to the child by possible or confirmed sexual abuse perpetrator exists.

3. **The SCP does not meet the child's needs for supervision, food, clothing, and/or medical or mental health care.**

- Nutritional needs of the child are not met, resulting in danger to the child's health and/or safety; the child appears malnourished; or there is insufficient food in the home.
- The child is without warm clothing in cold weather.
- The SCP does not seek treatment for the child's medical/dental/vision condition(s) or does not follow prescribed treatment for such conditions. (For example, not providing insulin for a child with diabetes, not providing follow-up care for a wound that is infected, not providing care for a broken bone, or overmedicating a child with prescribed or unprescribed medication.)
- The child has special needs, such as being medically fragile, which the SCP does not or cannot meet.
- The child has serious emotional symptoms, lack of behavioral control, or psychosomatic symptoms (e.g., sleep/appetite disturbance) and the SCP will not/cannot seek or provide appropriate interventions.
- The SCP does not attend to the child to the extent that the child's need for care goes unnoticed or unmet (e.g., the SCP is present but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).

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- The SCP leaves the child alone (time period varies with age and developmental stage).
- The SCP is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) or incapacitated (e.g., injured, ill).
- The SCP makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.

4. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:

- Leaking gas from stove or heating unit.
- Substances or objects accessible to the child that may endanger the health and/or safety of the child.
- Lack of water or utilities (heat, plumbing, electricity) and no alternate or safe provisions have been made.
- Open/broken/missing windows.
- Exposed electrical wires.
- Excessive garbage or rotted or 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 and other weapons are not locked.
- Unrestricted access to pool or other body of water.
- Blocked exits or unmarked exit routes.
- Missing or non-functioning smoke detectors.
- Ungated stairways.
- Unsafe sleeping arrangements.

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5. **The SCP routinely describes the child in negative terms or acts towards the child in negative ways.**

- The SCP describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
- The SCP routinely curses and/or repeatedly puts the child down.
- The SCP scapegoats a particular child in the household.
- The SCP blames the child for a particular incident or household problems.
- The SCP treats the child in markedly different ways that may stigmatize the child.
- The SCP interferes with the child's identity, reunification, or adoption (e.g., interferes with visitation or communication with birth parent, makes negative comments about the child's birth/adoptive family).
- The SCP undermines the validity and value of, or participation in, cultural support activities that are important to the child's cultural identity.

6. **The SCP fails to protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, neglect, or emotional abuse.**
The SCP fails to protect the child from harm or threatened harm as a result of physical abuse, neglect, sexual abuse, or emotional abuse by other family members, other household members, or others having regular access to the child.

- The SCP does not provide the supervision necessary to protect the child from potential harm by others, based on the child's age or developmental stage.
- An individual(s) with known violent criminal behavior/history resides in the household, or is allowed by the SCP to have access to the child.
- The SCP regularly takes the child to dangerous locations where drugs are manufactured or regularly administered (e.g., meth labs or drug houses, or locations used for prostitution or pornography).

7. **The SCP's explanation for an injury to the child is questionable or inconsistent with the type of injury.**
Factors to consider include the age of the child, location of the injury, exceptional needs of the child, or chronicity of injuries.

- Medical evaluation indicates injury is consistent with abuse; the SCP denies, or attributes injury to accidental causes.

  OR

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- There was a suspicious injury that did not require medical treatment but was located on an infant, or for older children, on the torso, face, or head; covered multiple parts of the body; appeared to be caused by an object; or is in different stages of healing.

  AND one of the following is true:

- The SCP's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury.

  OR

- The SCP denies abuse or attributes injury to accidental causes;

  OR

- The SCP's description of the injury or its cause minimizes the extent of harm to the child.

8. The SCP hinders/refuses access to the child.

- The SCP currently refuses or hinders access to the child and there has been a complaint of abuse and/or neglect.

- The SCP keeps the child at home, away from peers, school, and other outsiders for extended periods of time, for purposes of avoiding investigation.

- The SCP intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

9. Current circumstances, combined with prior referrals of abuse/neglect and/or incident reports, suggest that the child's safety may be of immediate concern.
There must be both current concerns AND related previous referrals/incidents that represent an emerging or unresolved pattern. Previous incidents may include any of the following:

- Prior incident reports, including any licensing complaints or citations.
- Prior referrals for abuse/neglect to the child.
- Evidence of prior unreported injuries or incidents.

10. Other (specify):
Circumstances or conditions that pose an immediate threat of serious harm to a child, which are not already described in safety threats 1–9.

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SECTION 1A: SUBSTITUTE CARE PROVIDER COMPLICATING BEHAVIORS

Substance abuse. The SCP has abused legal or illegal substances or alcoholic beverages in this incident to the extent that control of his/her actions or ***caregiving*** abilities is significantly impaired, or information is available that ***past abuse of legal or illegal substances has impaired the parent's caregiving capabilities in the past.***.

Domestic violence. There are indications of a recent history of one or more physical assaults between intimate members of the household, or threats/intimidation or harassment that are known as a result of self-report or other credible report by a family or other household member, friend, other collateral contacts, and/or police reports.

Mental health. The SCP appears to be mentally ill at the time of this incident or has a known history of mental health issues ***that have or could have impacted care of children***. The SCP may have a past diagnosis, hospitalization(s), or referrals for observation that are known as a result of self-report or other credible report by a family or other household member, friend, other collateral contacts, and/or police reports.

Developmental/cognitive impairment. The SCP may have diminished capacity as a result of developmental delays or cognitive issues ***that may impact their ability to provide care and supervision of children***.

Physical condition. The SCP has a physical condition that impacts care and protection of the child in the household.

SECTION 2. IN-HOME PROTECTIVE INTERVENTIONS

Safe with plan. One or more safety threats are present; however, the child can safely remain in home with a safety plan. In-home protective interventions have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Mark all in-home interventions used in the safety plan.

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes. Follow county policies whenever applying any of the safety interventions.

1. **Intervention or direct services by worker.**
   Actions taken or planned by the investigating worker or other CPS staff that specifically address one or more safety threats. Examples include providing information about nonviolent disciplinary methods, the child's 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 restraining orders; and providing definitions of child abuse laws and informing involved parties of consequences of violating these laws. DOES NOT INCLUDE the investigation itself, or services provided to respond to family needs that do not directly affect safety.

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2. **Use of family, neighbors, or other individuals in the community as safety resources.**
Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbors, or other individuals to mitigate safety concerns; agreement by a neighbor or relative to serve as a safety net for the child.

3. **Use of community agencies or services as safety resources.**
Involving community-based organizations, faith-related organizations, or other agencies in activities to address safety concerns. DOES NOT INCLUDE long term therapy or treatment or being put on a waiting list for services.

4. **Have the SCP appropriately protect the victim from the alleged perpetrator.**
The SCP has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator.

5. **Have the alleged perpetrator leave the household, either voluntarily or in response to legal action.**
Removal of the alleged perpetrator. Examples include arrest of alleged perpetrator, "kicking out" alleged perpetrator who has no legal right to residence, or perpetrator agrees to leave.

6. **Other (specify).**
The family or worker identifies a unique intervention for an identified safety concern that does not fit within items 1–5.

7. **Removal from current placement is necessary because interventions 1–6 do not adequately ensure the child's safety.**
One or more children will be removed from the current placement to an alternative placement resource.

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CALIFORNIA
SDM® SUBSTITUTE CARE PROVIDER SAFETY ASSESSMENT
POLICY AND PROCEDURES

Which Cases: All investigations of alleged abuse/neglect by an SCP, including the following:

- Licensed foster homes;
- Non-related extended family members (NREFM);
- Approved relative homes;
- Certified foster family agencies (FFA);
- Small family homes;
- Adoptive parents if the adoption has not yet been finalized; or
- Legal guardians, when a dependency case is still open (i.e., the department has protective responsibility for the child).

Excludes group homes, institutions, and residential treatment facilities.

When: As part of the investigation, prior to leaving the child in the home—documented within two working days of the first face-to-face contact with the alleged child victim. If needed, a subsequent SCP safety assessment may be completed to assess changes in safety during the investigation.

Who: The investigating social worker.

Decision: Guides the decision to remove a foster child from the SCP's home, based on whether threats to safety are present in the household and whether interventions are available and appropriate to maintain placement.

Appropriate Completion
Workers should familiarize themselves with the items that are included on the safety assessment and the accompanying definitions. Workers will notice that the items on the tool are very similar to the items on the SDM safety assessment for child protective service investigations.

Use of the safety assessment ensures that every worker is assessing the same items in each investigation of abuse/neglect by an SCP, and that the responses to these items lead to specific decisions. Once a worker is familiar with the items that must be assessed to complete the tool, the worker should conduct his/her initial contact as he/she normally would, using good social work practice to collect information from the child, SCP, and/or collateral sources. The SDM system ensures that the specific items that comprise the safety assessment are assessed at some time during the initial contact.

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Enter the name of the primary SCP and record the type of home being assessed. List the referral names and numbers of any related referrals for other foster children in the home. Complete one assessment per referral.

Additionally, record the names of all foster children in the home and their ages, including children in adoptive status for whom the adoption has not yet been finalized.

Enter the date the safety assessment was completed, which should be the date that the worker made initial face-to-face contact with the child(ren) to assess safety. This may be different than the date that the form is being completed in webSDM.

The safety assessment consists of four sections:

SECTION 1: SAFETY THREATS

This is a list of critical threats that must be assessed by every worker in every investigation of alleged abuse/neglect by an SCP. These threats cover the kinds of conditions that, should they exist, would render a child in danger of harm. Because not every conceivable safety threat can be anticipated or listed on a form, an "other" category permits a worker to indicate that some other circumstance creates a safety threat; that is, there is something other than the listed categories causing the worker to believe that the child is in danger of being harmed.

For this section, rely on information available at the time of the assessment. Workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is expected that not all facts about a case can be known immediately. Some information is inaccessible, and some may be deliberately hidden from the worker. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the 12 safety threats and accompanying definitions. For each item, consider all foster children in the home. If the safety threat is present, based on available information, mark that item "yes." If the safety threat is not present, mark that 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 "other" and briefly describe the threat.

If no safety threats are identified, the safety decision is "safe."

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. The SDM assessment guides the worker to leave the child in the placement for the present.

SECTION 1A: SUBSTITUTE CARE PROVIDER COMPLICATING BEHAVIORS

This section is completed only when there are safety threats identified as present in the household. If any of the safety threats were marked "yes" and there is evidence that one or more caregivers are experiencing substance abuse, mental health concerns, domestic violence, or cognitive/developmental or physical health concerns, indicate all that apply. These are conditions which make it more difficult or complicated to create safety for a child, but do not by themselves

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constitute a safety threat. These behaviors must be considered when assessing for and planning to mitigate safety threats. Mark all that apply to the household.

SECTION 2: IN-HOME PROTECTIVE INTERVENTIONS

This section is completed only if one or more safety threats are identified. If one or more safety threats are present, it does not automatically follow that a child must be removed from the SCP's home. In many cases, it will be possible to initiate a temporary plan that will mitigate the safety threat(s) sufficiently so that the child may remain in the placement while the investigation continues.

The safety intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential category of interventions and determine whether an intervention in that category is available and sufficient to mitigate the safety threat(s), and whether there is reason to believe the SCP 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 SCP would not follow through. The worker should keep in mind that while any single intervention may be insufficient to mitigate the safety threat(s), a combination of interventions may provide adequate safety. Also keep in mind that the safety intervention is not intended to solve the household's problems or provide long-term answers. A safety plan permits a child to remain in the placement during the course of the investigation.

If one or more safety threats are identified and the worker determines that interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will be removed from the SCP's home.

If one or more interventions will be implemented, mark each category that will be used. If there is an intervention that will be implemented that does not fit in one of the categories, mark item 6 and briefly describe the intervention. Safety intervention 7 is used only when it is determined that no interventions that would allow the current placement to continue are available or appropriate to mitigate safety threats.

Safe with plan. One or more safety threats are present; however, the child can safely remain in the placement with a safety plan.

Select this safety decision if one or more safety threats are identified and the worker is able to identify sufficient protective interventions that lead the worker to believe that the child may remain in the home for the present time.

Safety Plan

Individual counties should use their own safety plan form. The following must be included in any safety plan:

1. Each safety threat that has been identified and a description of the conditions or behaviors in the home that place any child at imminent threat of serious harm. The worker should use

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language the family understands so it is clear to them what caused the worker to identify the threat.

2. Detailed information for each planned safety intervention. What needs to happen to keep the child safe? Explain how safety threat(s) will be mitigated. What will the family do to keep the child safe? What will other people outside the family do? This should include a written statement of actions or behaviors to be taken by a responsible party, which will keep the child safe in the current conditions.

3. Who is participating in the plan, the role of each participant, and information that describes how the safety plan will be monitored (e.g., who is responsible for each intervention action) and the timeframe during which each intervention will remain in place.

4. Signature lines for family members, the worker, and his/her supervisor.

A SAFETY PLAN IS REQUIRED WHEN SAFETY DECISION IS "SAFE WITH PLAN."

Note: The safety plan should be documented in CWS/CMS.

The safety plan MUST be completed with the SCP, and a copy should be left with the family.

SECTION 3: PLACEMENT INTERVENTIONS

Unsafe. One or more safety threats are present, and removal from the SCP's household is the only protective intervention possible for one or more children.

The worker has determined that the child cannot be safely kept in the home, even after considering a complete range of interventions. It is possible that the worker will determine that interventions make it possible for one child to remain in the home while another must be removed. Select this safety decision if ANY child is removed from the home.

If one or more children are moved to another placement, list the names of foster children who are being removed from the home and the names of any foster children who were not removed from the home.

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CALIFORNIA
SDM® FAMILY RISK ASSESSMENT

Referral Name: _____ **Referral #:** _____ **Date:** _____/_____/_____

County Name: _____ **Worker Name:** _____ **Worker ID#:** _____

PRIOR INVESTIGATIONS	**Neglect**	**Abuse**
1. Prior neglect investigations		
○ a. No prior neglect investigations	0	0
○ b. One prior neglect investigation	0	1
○ c. Two prior neglect investigations	1	1
○ d. Three or more prior neglect investigations	2	1
2. Prior abuse investigations		
○ a. No prior abuse investigations	0	0
○ b. One prior abuse investigation	1	0
○ c. Two prior abuse investigations	1	1
○ d. Three or more prior abuse investigations	1	2
3. Household has previous or current open ongoing CPS case (voluntary/court ordered)		
○ a. No	0	0
○ b. Yes, but not open at the time of this referral	1	1
○ c. Yes, household has open CPS case at the time of this referral	2	2
4. Prior physical injury to a child resulting from child abuse/neglect or prior substantiated physical abuse of a child		
○ a. None/not applicable	0	0
○ b. One or more apply (*mark all applicable*) ☐ Prior physical injury to a child resulting from child abuse/neglect ☐ Prior substantiated physical abuse of a child	0	1

CURRENT INVESTIGATION	**Neglect**	**Abuse**
5. Current report maltreatment type *(mark all applicable)*		
☐ a. Neglect	1	0
☐ b. Physical and/or emotional abuse	0	1
☐ c. None of the above	0	0
6. Number of children involved in the child abuse/neglect incident		
○ a. One, two, or three	0	0
○ b. Four or more	1	1
7. Primary caregiver assessment of the incident		
○ a. Caregiver does not blame the child	0	0
○ b. Caregiver blames the child	0	1

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FAMILY CHARACTERISTICS	Neglect	Abuse
8. Age of youngest child in the home		
○ a. 2 years or older	0	0
○ b. Under 2	1	0
9. Characteristics of children in the household		
○ a. Not applicable	0	0
○ b. One or more present (*mark all applicable*)		
☐ Mental health or behavioral problems	1	1
☐ Developmental disability		
☐ Learning disability		
☐ Physical disability		0
☐ Medically fragile or failure to thrive		
10. Housing		
○ a. Household has physically safe housing	0	0
○ b. One or more apply (*mark all applicable*) ☐ Physically unsafe; AND/OR ☐ Family homeless	1	0
11. Incidents of domestic violence in the household in the past year		
○ a. None or one incident of domestic violence	0	0
○ b. Two or more incidents of domestic violence	0	1
12. Primary caregiver disciplinary practices		
○ a. Employs appropriate discipline	0	0
○ b. Employs excessive/inappropriate discipline	0	1
13. Primary or secondary caregiver history of abuse or neglect as a child		
○ a. No history of abuse or neglect for either caregiver	0	0
○ b. One or both caregivers have a history of abuse or neglect as a child	1	1
14. Primary or secondary caregiver mental health		
○ a. No past or current mental health problem	0	0
○ b. Past or current mental health problem *(mark all applicable)*	1	1
☐ During the past 12 months		
☐ Prior to the last 12 months		
15. Primary or secondary caregiver alcohol and/or drug use		
○ a. No past or current alcohol/drug use that interferes with family functioning	0	0
○ b. Past or current alcohol/drug use that interferes with family functioning *(mark all applicable)*	1	1
☐ Alcohol (☐ Last 12 months and/or ☐ Prior to the last 12 months)		
☐ Drugs (☐ Last 12 months and/or ☐ Prior to the last 12 months)		
16. Primary or secondary caregiver criminal arrest history		
○ a. No caregiver has prior criminal arrests	0	0
○ b. Either caregiver has one or more criminal arrests	1	0
	Neglect	**Abuse**
TOTAL SCORE		

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SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse indices, using the following chart.

Neglect Score	Abuse Score	Scored Risk Level
☐ 0–2	☐ 0–1	☐ Low
☐ 3–5	☐ 2–4	☐ Moderate
☐ 6–8	☐ 5–7	☐ High
☐ 9 +	☐ 8 +	☐ Very high

OVERRIDES

Policy Overrides. Mark yes if a condition shown below is applicable in this case. If <u>any</u> condition is applicable, override the final risk level to <u>very high</u>.

☐ Yes ☐ No 1. Sexual abuse case AND the perpetrator is likely to have access to the child.
☐ Yes ☐ No 2. Non-accidental injury to a child under age 2.
☐ Yes ☐ No 3. Severe non-accidental injury.
☐ Yes ☐ No 4. Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).

Discretionary Override. If a discretionary override is made, mark yes, increase risk by one level, and indicate reason.

☐ Yes ☐ No 5. If yes, override risk level (mark one): ☐ 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

Final Risk Level	Recommendation
Low	Do not promote*
Moderate	Do not promote*
High	Promote
Very high	Promote

*Unless there are unresolved safety threats.

PLANNED ACTION

☐ Promote
☐ Do not promote

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

_____

_____

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SUPPLEMENTAL RISK ITEMS

Note: These items should be recorded but are not scored.

1. Either caregiver demonstrates difficulty accepting one or more children's gender identity or sexual orientation.
   - ☐ a. No
   - ☐ b. Yes

2. Alleged perpetrator is an unmarried partner of the primary caregiver.
   - ☐ a. No
   - ☐ b. Yes

3. Another adult in the household provides unsupervised child care to a child under the age of 3.
   - ☐ a. No
   - ☐ b. Yes
   - ☐ c. N/A

3a. Is the other adult in the household employed?
   - ☐ a. No
   - ☐ b. Yes
   - ☐ c. N/A

4. Either caregiver is isolated in the community.
   - ☐ a. No
   - ☐ b. Yes

5. Caregiver has provided safe and stable housing for at least the past 12 months.
   - ☐ a. No
   - ☐ b. Yes

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CALIFORNIA
SDM® FAMILY RISK ASSESSMENT
DEFINITIONS

PRIOR INVESTIGATIONS

1. Prior neglect investigations

Identify whether there are prior investigations where neglect was alleged, substantiated, inconclusive, or unfounded. If there are prior investigations for neglect, identify the number of priors. Neglect includes severe and general neglect, exploitation (excluding sexual exploitation), and caregiver being absent/incapacitated, regardless of whether there were also abuse allegations in the investigation.

Do not include referrals that were not assigned for investigation.

Where possible, neglect history from other county or state jurisdictions should be included. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

For differential response referrals, include Paths 2 and 3.

Consider all adults in the household and count prior investigations for which they were alleged to be perpetrators (assign the highest score that applies).

a. Choose "a" if there were no investigations for any type of neglect prior to the current investigation.

b. Choose "b" if there was one investigation, substantiated or not, for any type of neglect prior to the current investigation.

c. Choose "c" if there were two investigations, substantiated or not, for any type of neglect prior to the current investigation.

d. Choose "d" if there were three or more investigations, substantiated or not, for any type of neglect prior to the current investigation.

2. Prior abuse investigations

Identify whether there are prior investigations where abuse was alleged, substantiated, inconclusive, or unfounded. If there are prior investigations for abuse, identify the number of priors. Abuse includes physical abuse, emotional abuse, or sexual abuse/exploitation, regardless of whether there were any neglect allegations in the investigation.

Do not include referrals that were not assigned for investigation.

Where possible, history from other county or state jurisdictions should be included. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

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For differential response referrals, include Paths 2 and 3.

Consider all adults in the household and count prior investigations for which they were alleged to be perpetrators (assign the highest score that applies).

a. Choose "a" if there were no investigations for any type of abuse prior to the current investigation.

b. Choose "b" if there was one investigation, substantiated or not, for any type of abuse prior to the current investigation.

c. Choose "c" if there were two investigations, substantiated or not, for any type of abuse prior to the current investigation.

d. Choose "d" if there were three or more investigations, substantiated or not, for any type of abuse prior to the current investigation.

3. Household has previous or current open ongoing CPS case (voluntary/court ordered)

Identify whether the household has previously had or currently has an open case as a result of a prior investigation. Service history includes voluntary or court-ordered family services or Family Preservation Services but does not include delinquency services. Select the highest-scoring applicable response.

a. Choose "a" if the household has not had an open CPS case prior to this investigation.

b. Choose "b" if the household has previously had an open CPS case and that case is not open at the time of this investigation.

c. Choose "c" if the household has a currently open CPS case at the time of this investigation that began prior to this investigation.

4. Prior physical injury to a child resulting from child abuse/neglect or prior substantiated physical abuse of a child

Identify whether a child has sustained a physical injury resulting from abuse and/or neglect by a current or former adult member of the household. Also identify whether any adult living in the household (caregiver or not) previously injured a child in an incident of abuse or neglect.

Injury sustained as a result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn.

a. Choose "a" if no child has sustained a physical injury resulting from abuse and/or neglect prior to this investigation OR no current adult household member has caused such an injury OR there is no prior substantiated physical abuse to a child involving a current household member as a perpetrator, regardless of whether the child is a prior or current household member.

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b. Choose "b" if a child sustained a physical injury resulting from abuse and/or neglect prior to this investigation that was not previously known to the agency, based on credible information from the child, caregivers, or others.

OR

Choose "b" if there was prior substantiated physical abuse of a child involving a current household member as a perpetrator, regardless of whether the child is a prior or current household member.

CURRENT INVESTIGATION

5. Current report maltreatment type (*mark all applicable*)

Identify whether the current report is for neglect, physical/emotional abuse, or both. This includes referred allegations or allegations made during the course of the investigation.

a. Choose "a" if the current report is for neglect.

b. Choose "b" if the current report is for physical and/or emotional abuse.

c. Choose "c" if the report does not include the above or is for sexual abuse/exploitation only.

6. Number of children involved in the child abuse/neglect incident

Identify the number of children less than 18 years of age for whom abuse or neglect was alleged or substantiated in the current investigation. If any child is removed as a result of the current investigation, count the child as residing in the home.

a. Choose "a" if there are one, two, or three children in the household.
b. Choose "b" if there are four or more children in the household.

7. Primary caregiver assessment of the incident

Identify whether the primary caregiver is supportive of the child in this incident or blames the child for the incident.

Blaming the child for the incident refers to the caregiver's statement that the maltreatment incident occurred because of the child's action or inaction (e.g., claiming that the child seduced him/her or the child deserved beating because he/she misbehaved).

a. Choose "a" if the primary caregiver does not blame the child for the incident.
b. Choose "b" if the primary caregiver does blame the child for the incident.

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FAMILY CHARACTERISTICS

8. Age of youngest child in the home

Identify the current age of the youngest child presently in the household where the maltreatment incident reportedly occurred. If a child is removed as a result of the current investigation, count the child as residing in the home.

a. Choose "a" if all children in the household are 2 years of age or older.
b. Choose "b" if any child in the household is younger than 2 years old.

9. Characteristics of children in the household

Identify whether any child in the household has a developmental, learning, and/or physical disability; is diagnosed as medically fragile or failure to thrive; or has mental health and/or behavioral issues. Base identification on credible information from a caregiver that a child has been diagnosed, statements from a physician or mental health professional, or review of records.

a. Choose "a" if no child in the household exhibits the characteristics listed in "b."

b. Choose "b" if any child in the household exhibits characteristics listed below and mark all types present. Mark all types that apply for any child in the household:

- Mental health or behavioral problems. Any child in the household has mental health or behavioral problems not related to a physical or developmental disability. This could be indicated by a diagnosis made by a mental health professional in an area that impacts daily functioning, receiving mental health treatment, attendance in a special classroom because of behavioral problems, or if the child is currently taking prescribed psychoactive medications.

- Developmental disability. A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

- Learning disability. Child has an individualized education plan (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 or failure to thrive.

  » "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,

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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 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 an ongoing threat to his/her continued well-being. Examples include a child who requires a trach-vent for breathing or a g-tube for eating.

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

10. Housing

Identify the family's current housing status.

a. Choose "a" if the family has housing that is physically safe.

b. Choose "b" if either of the following applies (mark all applicable).

- The family has housing, but the current housing situation is physically unsafe to the extent that it does not meet the health or safety needs of the child (e.g., exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, rotting food).

AND/OR

- The family is homeless or was about to be evicted at the time the investigation began or the family becomes homeless/receives an eviction notice by the time the risk assessment is completed. Consider as "homeless" people who are living in a shelter and those living on a short-term basis with relatives or friends.

11. Incidents of domestic violence in the household in the past year

Identify whether there has been domestic violence in the household in the past year. Identification may be based on a credible report from the caregiver(s), police reports, or other records.

a. Choose "a" if, in the previous year, there has been one domestic violence incident or no domestic violence has occurred in the household.

b. Choose "b" if in the previous year, there have been two or more physical assaults or multiple periods of intimidation/threats/harassment in the household between caregivers or between a caregiver and another adult.

12. Primary caregiver disciplinary practices

Identify the disciplinary practices of the primary caregiver of the child in the household.

a. Choose "a" if the primary caregiver employs appropriate discipline.
b. Choose "b" if the primary caregiver employs excessive/inappropriate discipline.

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Include excessively harsh physical or emotional disciplinary practices that caused or threatened harm to the child and/or were inappropriate given the child's age or development. Do not choose "b" if the actions of the caregiver that have caused harm or injury bear no resemblance to discipline.

Examples of excessive/inappropriate discipline include but are not limited to locking the child in a closet or basement, holding the child's hand over fire, hitting the child with dangerous implements, or depriving a young child of physical and/or social activity for extended periods.

13. Primary or secondary caregiver history of abuse or neglect as a child

Identify whether either caregiver was maltreated as a child. Maltreatment includes neglect or physical, sexual, or emotional abuse.

a. Choose "a" if there are no credible statements by the primary or secondary caregiver or others, or state records of past allegations, that indicate either caregiver was maltreated as a child.

b. Choose "b" if credible statements by the primary or secondary caregiver or others, or state records of past allegations, indicate that either caregiver was maltreated as a child.

14. Primary or secondary caregiver mental health

Identify the primary and secondary (if present) caregivers' mental health statuses.

a. Choose "a" if the primary and secondary (if present) caregivers do not have past or current mental health problems.

b. Choose "b" if credible and/or verifiable statements by the primary and/or secondary caregiver or others indicate that the primary and/or secondary caregiver:

- Has been diagnosed as having a significant mental health disorder that impacts daily functioning, as determined by a mental health professional; OR
- Has had repeated referrals for mental health/psychological evaluations; OR
- Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

If "b," indicate whether the identified mental health problem is current (present in the last 12 months) and/or was present prior to the last 12 months before this referral.

15. Primary or secondary caregiver alcohol and/or drug use

Identify the primary and secondary (if present) caregivers' alcohol and/or drug use, both current and historical, and whether it interferes or has interfered with family functioning.

a. Choose "a" if the primary or secondary caregiver does not have and never has had a drug or alcohol problem that interferes with family functioning.

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b. Choose "b" if the primary or secondary caregiver has past or current alcohol and/or drug use that interferes with his/her or the family's functioning. Such interference is evidenced by:

- Substance use that affects or affected employment, criminal involvement, or marital or family relationships; and/or that affects or affected caregiver's ability to provide protection, supervision, and care for the child;
- An arrest in the past two years for driving under the influence (DUI) or refusing breathalyzer testing;
- Self-report of a problem;
- Treatment received currently or in the past;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use and/or abuse; or
- The child's diagnosis with fetal alcohol syndrome or exposure, or the child's positive toxicology screen at birth and the primary caregiver was the birth parent.

If "b," indicate whether the identified substance use problem is current (present in the last 12 months) and/or was present prior to the last 12 months before this referral.

16. Primary or secondary caregiver criminal arrest history

Indicate whether either the primary or secondary caregiver has a criminal arrest history prior to the current complaint as either an adult or a juvenile. This includes DUIs but excludes all other traffic offenses.

Information may be located in the case narrative material, reports from other agencies, self-report, etc. Also review any police reports in the file for this information.

a. Choose "a" if neither caregiver has criminal arrests prior to this complaint.

b. Choose "b" if either caregiver has one or more criminal arrests prior to the current complaint.

POLICY OVERRIDES

Mark yes if a condition listed below is applicable in this case. If <u>any</u> condition is applicable, override the final risk level to <u>very high</u>.

1. Sexual abuse case AND the perpetrator is likely to have access to the child.

One or more of the children in this household are or have been victims of sexual abuse AND the perpetrator is likely to have unmanaged access.

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2. **Non-accidental injury to a child under age 2.**
Any child under 2 years old in the household has any kind of physical injury resulting from the actions or inactions of a caregiver.

3. **Severe non-accidental injury.**
Severe non-accidental injury includes, for example, brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that requires medical treatment and seriously impairs the health or well-being of the child.

4. **Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).**
Any child in the household has died as a result of actions or inactions by the caregiver. This child fatality may have occurred prior to the current case. Mark this override if this condition has ever existed within the household.

DISCRETIONARY OVERRIDE

A discretionary override is used by the ongoing worker whenever the worker believes that the risk score does not accurately portray the household's actual risk level. The worker may only increase the risk level. If the worker applies a discretionary override, the reason should be specified and the final risk level should be marked.

SUPPLEMENTAL RISK ITEMS

1. **Either caregiver demonstrates difficulty accepting one or more children's gender identity or sexual orientation.**
Identify whether either caregiver in the household indicates a lack of acceptance of a child's gender identity or sexual orientation. A lack of acceptance may be indicated by verbal statements (calling names, derogatory statements, etc.); actions (physical aggression, kicking the child out, etc.); or a lack of caregiver support, such as a failure to acknowledge the child's gender identity or sexual orientation.

   a. Choose "No" if neither caregiver demonstrates difficulty.
   b. Choose "Yes" if either caregiver demonstrates difficulty.

2. **Alleged perpetrator is an unmarried partner of the primary caregiver.**
Identify whether an alleged perpetrator in this incident is an unmarried partner of the primary caregiver in the household. The primary caregiver may or may not also be an alleged perpetrator.

   a. Choose "No" if an alleged perpetrator is not an unmarried partner.
   b. Choose "Yes" if an alleged perpetrator is an unmarried partner.

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3. Another adult in the household provides unsupervised child care to a child under the age of 3.

Identify whether another adult in the household (birth or adoptive parent, stepparent, significant other, or roommate) provides unsupervised child care to any child in the household who is younger than 3.

a. Choose "No" if a birth or adoptive parent, stepparent, significant other, or roommate in the household does not provide unsupervised care for a child younger than 3.

b. Choose "Yes" if a birth or adoptive parent, stepparent, significant other, or roommate in the household does provide unsupervised care for a child younger than 3.

c. Choose "N/A" (not applicable) if there is only a primary caregiver in the household.

3a. Is the other adult in the household employed?

Identify whether the other adult in the household (birth or adoptive parent, stepparent, significant other, or roommate) is employed or not.

a. Choose "No" if the other adult in the household (birth or adoptive parent, stepparent, significant other, or roommate) providing unsupervised care to a child in the household younger than 3 is not employed.

b. Choose "Yes" if the other adult in the household (birth or adoptive parent, stepparent, significant other, or roommate) providing unsupervised care to a child in the household younger than 3 is employed.

c. Choose "N/A" if there is only a primary caregiver in the household.

4. Either caregiver is isolated in the community.

Identify whether either caregiver in the household is isolated in the community, as evidenced by lack of communication with others, a lack of meaningful relationships, or a lack of access to community resources.

a. Choose "No" if both caregivers have relationships in the community for support.
b. Choose "Yes" if either caregiver is isolated in the community.

5. Caregiver has provided safe and stable housing for at least the past 12 months.

Identify whether the caregiver has provided safe and stable housing for the last 12 months as evidenced by housing that is physically safe for the child.

a. Choose "No" if the family has had frequent moves or if there are environmental conditions that pose a threat to the child.

b. Choose "Yes" if the family has had safe and stable housing.

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CALIFORNIA
SDM® FAMILY RISK ASSESSMENT
POLICY AND PROCEDURES

The SDM family risk assessment identifies families with low, moderate, high, or very high probabilities of future abuse or neglect. By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their child in the next 18 to 24 months. The difference between risk levels is substantial. Families classified as high risk have significantly higher rates of subsequent referral and substantiation than families classified as low risk, and they are more often involved in serious abuse or neglect incidents.

When risk is clearly defined and objectively quantified, the choice between serving one family or another is simplified: agency resources are targeted to families at higher risk because of the greater potential to reduce subsequent maltreatment.

The risk assessment is based on research on cases with substantiated abuse or neglect, which examined the relationships between family characteristics and the outcomes of subsequent substantiated abuse and neglect. The tool does not predict recurrence but simply assesses whether a family is more or less likely to have another incident without intervention by the agency.

Which Cases: Required for all substantiated and inconclusive referrals; also recommended to be completed on unfounded referrals. This includes new assigned referrals on open cases.

Who: The social worker who is responding to the referral.

When: After the safety assessment has been completed and the worker has reached a conclusion regarding the allegation AND prior to the decision to promote to a case or close without continuing services. This is no later than 30 days from the first face-to-face contact.

For children in out-of-home care with a "return home" goal, if a second parent living in a separate household will receive child welfare services, complete a baseline risk assessment within 30 days of identifying that parent. (Note: This risk assessment is completed within a *case* in webSDM.)

Decision: Identifies the level of risk of future maltreatment. The risk level guides the decision to close a referral or promote a referral to a case and recommends minimum contact frequency standards for open cases based on risk (see Section VI of this manual).

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Risk-Based Case Open/Close Guide	
Risk Level	**Recommendation**
Low	Close*
Moderate	Close*
High	Open
Very High	Open

*When safety threats are still present at the end of the investigation, the referral should be promoted to a case regardless of risk level.

Appropriate Completion
The risk assessment is completed based on conditions that exist at the time the incident is reported and investigated as well as the prior history of the family.

- Only one household can be assessed on the risk assessment form.
- Always assess the household in which the child abuse/neglect incident is alleged. If a child is a member of two households and there are allegations on both households, complete a risk assessment on both households.
- Complete a second risk assessment for non-custodial parents who will receive reunification services.

Scoring Individual Items
Workers should familiarize themselves with the items that are included on the risk assessment and the accompanying definitions for those items. A score for each assessment item is derived from the worker's observation of the characteristics the item describes during interviews with household members (child, caregivers, and others) and collaterals; worker observations; reports and case records; or other reliable sources. Some characteristics are objective (such as prior child abuse/neglect history or the age of the child). Others require the worker to use discretionary judgment based on his/her assessment of the family, through use of the definitions.

After all risk items are scored, the score is totaled and indicates the corresponding risk levels for both subsequent neglect and subsequent abuse. Next, the scored risk level is determined; it is the higher between the abuse and the neglect risk levels).

Overrides
After completing the risk assessment, the worker considers whether reasons to override the scored risk level are present. There are two types of overrides.

Policy Overrides
Policy overrides reflect incident seriousness and/or child vulnerability concerns and have been determined by the agency to warrant a risk level designation of "very high," regardless of the risk level indicated by the assessment tool. Policy overrides require supervisory approval. Consider each of the four policy override reasons and mark yes or no as appropriate for each policy override.

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Discretionary Override
A discretionary override is used by the worker to increase the risk level in any case in which the worker believes that the scored risk level determined by the risk assessment is too low. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the risk assessment. When used, a discretionary override increases the scored risk level by one level (e.g., from low to moderate OR moderate to high, but NOT from low to high). Discretionary overrides require a written description of the reasons to increase the risk level and supervisory approval.

After completing the override section, indicate the final risk level, which is the highest of the scored risk level, policy override risk level (which is always very high), and the discretionary risk level.

Disposition
WebSDM will display the recommended response based on the risk-based case open/close guide and the most recent safety decision. High-risk and very high-risk referrals are recommended to be opened for ongoing services, while low-risk and moderate-risk referrals are recommended for closure **unless** there is a current safety decision of "safe with plan" or "unsafe." Enter the actual case disposition (promoted to case or not promoted to case). If the recommended response differs from the actual disposition, provide an explanation.

Examples of explanation include the following:

- Promoting a low-risk or moderate-risk family to a case:
  - » Unresolved safety threats. Based on the SDM safety assessment, one or more safety threats could not be resolved.
- Not promoting a high-risk or very high-risk family to a case:
  - » Family declined voluntary family maintenance AND no petition. Family was informed of their high or very high risk level and was encouraged to accept voluntary family maintenance services. The family declined AND no petition will be filed. Mark this item even if family does accept any non-CPS services.
  - » Family is receiving or has been connected with community services that will address priority needs and/or contributing factors. The family is already engaged in services OR the worker will assist the family in making connections to community services (worker must be certain that an appointment was made and verify follow-through). These services are directly related to the priority needs identified using the family strengths and needs assessment or other means to identify factors that contribute to risk.

Supplemental Risk Items
These are items that are answered for each investigation in which a risk assessment is completed. The purpose of the supplemental risk items is to gather information on in areas that are thought to have a relationship to subsequent harm. The supplemental risk items are used in validation of the risk assessment, which occurs every five to seven years. Use the definitions to answer the items and gather the information for the answers in the same way as the risk assessment items.

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CALIFORNIA
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT

Case Name: _____ **Case #:** _____ **Date:** ____/____/____
County Name: _____ **Worker Name:** _____ **Worker ID#:** _____
Household Name: _____

SECTION 1: CAREGIVER STRENGTHS AND NEEDS ASSESSMENT

☐ Primary **Primary Caregiver Name:** _____

☐ Secondary **Secondary Caregiver Name:** _____

Race (mark all that apply): ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Latino/a ☐ Multiracial ☐ White ☐ Other

Ethnicity: _____

Tribal Affiliation: ☐ Yes ☐ No ☐ Parent Not Available ☐ Parent Unsure

Tribe Name: _____ **Federally Recognized:** ☐ Yes ☐ No

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Not discussed

Gender Identity/Expression: ☐ Female ☐ Male ☐ Transgender ☐ Other

Religious/Spiritual Affiliation: _____

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

A. Household Context

The caregiver's perspective of culture and cultural identity:

P	S	
☐	☐	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Consider how the family's culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence or shape parenting and caregiving. Are there contacts or services within this culture that can be mobilized in the case plan to enhance safety now or over time?

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B. Caregiver Domains

Indicate whether the caregiver's behaviors in each domain (a) actively help create safety, permanency, or well-being for the child/youth/young adult; (b) are neither a strength nor a barrier for child/youth/young adult safety, permanency, or well-being; (c) make it difficult to create long-term safety, permanency, or well-being (i.e., are a barrier); or (d) directly contribute to a safety threat.

Always select the highest priority that applies, e.g., if caregiver actions fit definitions "c" and "d," select "d."

Domains and behaviors identified as "d" 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 "d."

SN1. Resource Management/Basic Needs

The caregiver's resources and management of resources:

P	S	
☐	☐	a. Actively help create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN2. Physical Health

The caregiver's physical health:

P	S	
☐	☐	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN3. Parenting Practices

The caregiver's parenting practices:

P	S	
☐	☐	a. Actively help create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Are not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Are a barrier to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN4. Social Support System

The caregiver's social support system:

P	S	
☐	☐	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN5. Household and Family Relationships

The caregiver's relationships with other adult household members:

P	S	
☐	☐	a. Actively help create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN6. Domestic Violence

The caregiver's intimate relationships:

P	S	
☐	☐	a. Actively help create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN7. Substance Use

The caregiver's actions regarding substance use:

P	S	
☐	☐	a. Actively help create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Are not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Are a barrier to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

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SN8. Mental Health

The caregiver's mental health:

P	S	
☐	☐	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN9. Prior Adverse Experiences/Trauma

The caregiver's response to prior adverse experiences/trauma:

P	S	
☐	☐	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN10. Cognitive/Developmental Abilities

The caregiver's developmental and cognitive abilities:

P	S	
☐	☐	a. Actively help create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN11. Other Identified Caregiver Strength or Need (not covered in SN1–SN10)

☐ Not applicable.

An additional need or strength has been identified that:

P	S	
☐	☐	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
☐	☐	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
☐	☐	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
☐	☐	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Description of behaviors:

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C. Priority Needs and Strengths

Enter the item number and description of all of the most serious needs ("d"s first, then "c"s) from items SN1–SN11 for each caregiver (P=Primary; S=Secondary, B=Both). Then identify which are a priority for closure.

The family's priority needs should all be included in the family case plan.

NEEDS			
Score ("d"s then "c"s)	**Domain Name**	**Caregiver**	**Priority for Closure? (required if score is "d")**
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No

Enter the item number and description of all of the family's strengths ("a" answers) from items SN1–SN11 for each caregiver (P=Primary; S=Secondary, B=Both). These family strengths can be used to address the priority needs identified above.

STRENGTHS			
Score ("a"s)	**Domain Name**	**Caregiver**	**Include in Family Case Plan?**
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No
		☐ Primary ☐ Secondary ☐ Both	☐ Yes ☐ No

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SECTION 2: CHILD/YOUTH/YOUNG ADULT STRENGTHS AND NEEDS ASSESSMENT
Repeat this section for each child/youth/young adult in the family.

Child/Youth/Young Adult Name: _____

Race (mark all that apply): ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Latino/a ☐ Multiracial ☐ White ☐ Other

Ethnicity: _____

Tribal Affiliation: ☐ Yes ☐ No ☐ Parent Not Available ☐ Parent Unsure

Tribe Name: _____ **Federally Recognized:** ☐ Yes ☐ No

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Not discussed

Gender Identity/Expression: ☐ Female ☐ Male ☐ Transgender ☐ Other

Religious/Spiritual Affiliation: _____

Other Cultural Identity Important to Child/Youth/Young Adult (e.g., immigration status, disability status)**:**

_____

A. Household Context

The child/youth/young adult's perspective of culture, cultural identity, norms, and past/current experiences of discrimination:

☐ a. Help him/her create safety, permanency, and well-being for him/herself.
☐ b. Have no effect on his/her safety, permanency, or well-being.
☐ c. Make it difficult for him/her to experience long-term safety, permanency, or well-being.
☐ d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Consider how the child/youth/young adult's culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence him/her. Are there contacts or services within this culture that can be mobilized in the case plan?

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B. Child/Youth/Young Adult Domains

Indicate whether the behaviors of the child/youth/young adult in each domain (a) actively help create safety, permanency, or well-being for him/herself; (b) are neither a strength nor a barrier for his/her safety, permanency, or well-being; (c) make it difficult to create long-term safety, permanency, or well-being (i.e., are a barrier); or (d) directly contribute to a safety threat.

Always select the highest priority that applies, e.g., if child/youth/young adult actions fit definitions "c" and "d," select "d."

Domains and behaviors identified as "d" 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 "d".

CSN1. Emotional/Behavioral Health

- ☐ a. The child/youth/young adult's emotional/behavioral health contributes to his/her safety.
- ☐ b. The child/youth/young adult does not have an emotional/behavioral concern OR the child/youth/young adult has an emotional/behavioral health concern, but no additional intervention is needed.
- ☐ c. The child/youth/young adult has an emotional/behavioral health concern, AND it is an ongoing unmet need.
- ☐ d. The child/youth/young adult has an emotional/behavioral health concern that directly contributes to danger to the child/youth/young adult.

CSN2. Trauma

- ☐ a. The child/youth/young adult's response to prior trauma contributes to his/her safety.
- ☐ b. The child/youth/young adult has not experienced trauma OR the child/youth/young adult has experienced trauma but no additional intervention is needed.
- ☐ c. The child/youth/young adult's response to prior trauma is a concern AND it is an ongoing unmet need.
- ☐ d. The child/youth/young adult's response to prior trauma is a concern that directly contributes to danger to the child/youth/young adult.

CSN3. Child Development

- ☐ a. The child/youth/young adult's development is advanced.
- ☐ b. The child/youth/young adult's development is age-appropriate.
- ☐ c. The child/youth/young adult's development is limited.
- ☐ d. The child/youth/young adult's development is severely limited.

(shown in webSDM if "d" is marked)

- ☐ A regional center referral has been completed.

CSN4. Education

- ☐ a. The child/youth/young adult has outstanding academic achievement.
- ☐ b. The child/youth/young adult has satisfactory academic achievement OR the child/youth/young adult is not of school age.
- ☐ c. The child/youth/young adult has academic difficulty.
- ☐ d. The child/youth/young adult has severe academic difficulty.

Also indicate if:

- ☐ The child/youth/young adult has an individualized education plan.
- ☐ The child/youth/young adult has an educational surrogate parent.
- ☐ The child/youth/young adult needs an educational surrogate parent.
- ☐ The child/youth/young adult is required by law to attend school but is not attending.

CSN5. Social Relationships

- ☐ a. The child/youth/young adult has strong social relationships.
- ☐ b. The child/youth/young adult has adequate social relationships.
- ☐ c. The child/youth/young adult has limited social relationships.
- ☐ d. The child/youth/young adult has poor social relationships.

CSN6. Family Relationships

- ☐ a. The child/youth/young adult's relationships within his/her family contribute to his/her safety.
- ☐ b. The child/youth/young adult's relationships within his/her family do not impact his/her safety.
- ☐ c. The child/youth/young adult's relationships within his/her family interfere with long-term safety.
- ☐ d. The child/youth/young adult's relationships within his/her family contribute to danger of serious physical or emotional harm to the child/youth/young adult.

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CSN7. Physical Health/Disability

- ☐ The child/youth/young adult's immunizations are current.
- ☐ a. The child/youth/young adult has no health care needs or disabilities.
- ☐ b. The child/youth/young adult has minor health problems or disabilities that are being addressed with minimal intervention and/or medication.
- ☐ c. The child/youth/young adult has health care needs or disabilities that require routine interventions.
- ☐ d. The child/youth/young adult has serious health/disability needs that require ongoing treatment and interventions by professionals or trained caregivers AND/OR the child/youth/young adult has an unmet medical need.

CSN8. Alcohol/Drugs

- ☐ a. The child/youth/young adult actively chooses an alcohol- and drug-free lifestyle.
- ☐ b. The child/youth/young adult does not use or experiment with alcohol/drugs.
- ☐ c. The child/youth/young adult's alcohol and/or other drug use results in disruptive behavior and conflict.
- ☐ d. The child/youth/young adult's chronic alcohol and/or other drug use results in severe disruption of functioning.

CSN9. Delinquency

- ☐ a. The child/youth/young adult has no delinquent behavior. There is no indication of delinquent history or behavior.
- ☐ b. The child/youth/young adult has no delinquent behavior in the past two years.
- ☐ c. The child/youth/young adult is/has engaged in delinquent behavior and may have been arrested or placed on probation in the past two years.
- ☐ d. The child/youth/young adult is or has been involved in any violent, or repeated nonviolent, delinquent behavior.

  Also indicate "d" if:
  - ☐ The child/youth/young adult has been adjudicated a WIC Section 602 ward.
  - ☐ The child/youth/young adult is in need of a WIC Section 241.1 hearing.

CSN10. Relationship With Substitute Care Provider (if child/youth/young adult is in care)

- ☐ Not applicable; child/youth/young adult is not in care.
- ☐ a. The child/youth/young adult has developed a strong attachment to at least one substitute care provider.
- ☐ b. The child/youth/young adult has no conflicts with the substitute care provider.
- ☐ c. The child/youth/young adult has some conflicts with the substitute care provider that have resulted or may result in the child/youth/young adult feeling unsafe or unaccepted in the placement; however, with support, these issues can be mitigated.
- ☐ d. The child/youth/young adult has serious conflicts with one or more members of the current substitute care provider's household.

CSN11. Independent Living (if age 15.5 or older)

- ☐ Not applicable.
- ☐ a. The youth/young adult is prepared to function as an adult.
- ☐ b. The youth/young adult is making progress toward being prepared for adulthood.
- ☐ c. The youth/young adult is attempting to prepare for adulthood but lacks the confidence, emotional maturity, and/or sufficient skills to live independently.
- ☐ d. The youth/young adult is not prepared or is refusing to prepare for adulthood.

For youth/young adult age 15.5 and older, check all that apply to preparation for adulthood.

- ☐ The youth/young adult is receiving assistance from a regional center.
- ☐ The 15.5-year-old assessment has been completed.
- ☐ For youth/young adults age 16 or older, a referral to formal services and a credit check application have been completed.
- ☐ For youth/young adults age 17 and older, an independent living plan has been completed.
- ☐ An exit plan meeting has been held.
- ☐ An exit from foster care meeting has been held.
- ☐ The youth/young adult is participating in the extension foster care program (AB 12).

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CSN12. Other Identified Child/Youth/Young Adult Strength or Need (not covered in CSN1–CSN11)

☐ Not applicable.

An additional need or strength has been identified that:

☐ a. Actively helps him/her create safety, permanency, and well-being for him/herself.
☐ b. Is not a strength or barrier for safety, permanency, or well-being.
☐ c. Is a barrier to his/her safety, permanency, or well-being.
☐ d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Description of behaviors:

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C. Priority Needs and Strengths

Enter the item number and description of all of the most serious needs ("d"s first, then "c"s) from items CSN1–CSN12 for each child/youth/young adult.

The child/youth/young adult's priority needs ("d" answers) should all be included in the family case plan.

Score ("d"s, then "c"s)	Domain Name and Description

Use the table below to identify child/youth/young adult strengths ("a" answers) from items CSN1–CSN12 that can contribute to addressing the priority needs identified above.

STRENGTHS		
Score ("a"s)	**Domain Name**	**Include in Family Case Plan?**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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CALIFORNIA
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT
(FOR CAREGIVERS AND CHILDREN)
DEFINITIONS

SECTION 1: CAREGIVER STRENGTHS AND NEEDS ASSESSMENT

A. Household Context

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 a family member's race (African American/Black, American Indian/Alaska Native, Asian/Pacific Islander, Latino/a, multiracial, White, other), ethnicity, tribal affiliation, sexual orientation (heterosexual, gay, lesbian, bisexual), gender identity/expression (female, male, transgender, other), religious/spiritual affiliation, disability, or other social identity that reflects the family's unique characteristics.*

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 nonmainstream culture and may refer to the mainstream culture.

> *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:

- How the caregiver identifies him/herself (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 childrearing?
How do all of the above influence or shape the caregiver's actions with his/her children?

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The caregiver's perspective of culture and cultural identity:

a. Actively helps create safety, permanency, and child/youth/young adult well-being. The caregiver draws upon his/her culture to respond to challenges in ways that create safety for the child/youth/young adult.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being. The caregiver is connected to a culture and/or identifies with a culture and this has no impact on child/youth/young adult safety.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being. The caregiver is connected to a culture and/or identifies with a culture in ways that cause struggles for the child/youth/young adult, such as mild to moderate conflict with the caregiver over culture/cultural identity or disrupted relationships with the child/youth/young adult based on cultural differences.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult. The caregiver is connected to a culture and/or identifies with a culture in ways that cause danger for the child/youth/young adult, such as physically or emotionally harming the child/youth/young adult over differences in culture/cultural identity.

B. 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, permanency, and well-being of a child/youth/young adult. 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 his/her ability to effectively provide for the child/youth/young adult's safety.

SN1. Resource Management/Basic Needs

Consider the caregiver's management of available financial resources to meet basic care needs related to the child/youth/young adult's health and safety.

The caregiver's resources and management of resources:

a. Actively help create safety, permanency, and child/youth/young adult well-being. The caregiver has a history of consistently providing adequate housing, food, and clothing. The caregiver has the ability to problem solve and proactively seek resources to meet the family's ongoing needs.

b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being. The caregiver has adequate housing, food, and clothing. The caregiver adequately and/or successfully manages available resources to meet basic care needs related to health and safety.

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OR

The caregiver may have limited/no income, but he/she 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., caregiver has a plan for the next six months).

c. Are barriers to safety, permanency, or child/youth/young adult well-being.

- The caregiver provides housing, but it is in poor repair due to inadequate utilities or housekeeping.
- Caregiver may have limited/no income, and he/she 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/youth/young adult's basic needs.
- The family may be homeless; however, there is no evidence of harm or threat of harm to the child/youth/young adult.
- 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/youth/young adult has not experienced harm or threat of harm.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult. Considering the age and vulnerability of the child/youth/young adult, resource conditions exist in the household that have already caused illness or injury to family members, or are immediately likely to cause illness or injury, such as:

- Inoperable plumbing, heating, or wiring, causing an imminent threat of harm to the child/youth/young adult;
- No food, food is spoiled, or family members are malnourished;
- Child/youth/young adult chronically presents with clothing that is unclean, not appropriate for weather conditions, or in poor repair to the extent that the child/youth/young adult 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/youth/young adult; 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

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child/youth/young adult's basic needs unmet while using resources for other priorities.

SN2. Physical Health

When assessing, consider both the diagnosed or suspected condition AND the impact that such conditions have on the caregiver's ability to adequately parent and protect the child/youth/young adult. The condition itself does not necessitate the selection of "d."

The caregiver's physical health:

a. Actively helps create safety, permanency, and child/youth/young adult well-being. The caregiver has no current health concerns that affect family functioning. The caregiver proactively seeks preventive health care for him/herself and the family. The caregiver promotes a healthy lifestyle, including nutrition, physical activity, and recreational activities that promote overall health and well-being.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being. 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 the child/youth/young adult's needs. Caregiver may have a medical condition, but he/she is consistently able to meet the child/youth/young adult's needs (e.g., caregiver with mild or well-controlled lupus who is able to participate in most of the child/youth/young adult's activities, and child/youth/young adult is not experiencing a sense of loss).

c. Is a barrier to safety, permanency, or child/youth/young adult well-being. Examples of caregiver conditions include but are not limited to the following:

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

- Caregiver may occasionally struggle to meet child/youth/young adult's needs because of health limitations (e.g., chronic medical condition, physical disability), and child/youth/young adult's needs are sometimes unmet.

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

Examples of impact on the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may occasionally worry or feel stress about caregiver's health, but such worry does not interfere with his/her 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 nonsignificant impact on the child/youth/young adult; caregiver's lupus

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makes it impossible for him/her to participate fully in child/youth/young adult's activities, and child/youth/young adult feels sad).

- Child/youth/young adult may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.

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

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult. 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/youth/young adult.

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

Examples of threats of serious harm to the child/youth/young adult include but are not limited to the following:

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

- Child/youth/young adult may assume parenting responsibilities for self or siblings in ways that interfere with development or functioning.

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

Caregiver cannot meet child/youth/young adult's needs for food, shelter, or supervision (e.g., caregiver has severe lupus and has been unable to feed infant, and infant has been diagnosed with failure to thrive, or there have been so many 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/youth/young adult needs).

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SN3. Parenting Practices

Parenting practices include knowledge, skills, and abilities demonstrated by the parent or caregiver.

Note: 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/youth/young adult may be frowned upon. This should not be interpreted as inappropriate parenting unless there is evidence that this behavior is harmful to the child/youth/young adult.

The caregiver's parenting practices:

a. Actively help create safety, permanency, and child/youth/young adult well-being. The caregiver displays exceptional parenting patterns that are age-appropriate for the child/youth/young adult in the areas of expectations, discipline, communication, protection, and nurturing. The caregiver has the basic knowledge and skills to provide care. Examples of such parenting include but are not limited to the following:

- Caregiver recognizes and expresses hope for the child/youth/young adult's abilities/strengths.
- Caregiver has the ability to recognize and respond to the child/youth/young adult's cues.
- Caregiver has an understanding of age- and developmentally appropriate expectations for the child/youth/young adult and promotes and encourages activities such as (but not limited to):
  - » Developmental play groups;
  - » Occupational/physical therapy or other developmental services; or
  - » School-, church-, or community-based activities appropriate for the child/youth/young adult's age.
- The caregiver spends quality time with the child/youth/young adult and supports the child/youth/young adult when he/she is upset.

b. Are not a strength or barrier for safety, permanency, or child/youth/young adult well-being. The caregiver displays adequate parenting patterns that are age-appropriate for the child/youth/young adult in the areas of expectations, discipline, communication, protection, and nurturing. The caregiver has the basic knowledge and skills to provide care. Examples of such parenting include but are not limited to the following:

- When the child/youth/young adult errs, caregiver provides nonviolent intervention. Interventions and communication of expectations may not be perfectly consistent, but, at a minimum, they are generally effective in helping

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the child/youth/young adult understand limits and self-regulate behavior (as age-appropriate).

- Child/youth/young adult is growing to have a developmentally appropriate sense of behavioral expectations and is learning to manage his/her behavior well.

- Caregiver provides adequately for child/youth/young adult's basic needs.

- Minimally, caregiver periodically spends time with child/youth/young adult, supports child/youth/young adult when child/youth/young adult is upset, and lets child/youth/young adult know that he/she is loved and valued.

c. Are a barrier to safety, permanency, or child/youth/young adult well-being. Examples of such parenting include but are not limited to the following:

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

- Caregiver frequently fails to meet some of child/youth/young adult's basic needs, often because caregiver did not notice or was unaware of the child/youth/young adult's need. Child/youth/young adult experiences so much worry over basic needs that he/she is developing symptoms such as lack of concentration, difficulty sleeping, hoarding, or stealing food.

- Caregiver seldom expresses love or value for the child/youth/young adult. Child/youth/young adult may worry about his/her place in the life of the caregiver and/or may frequently experience self-doubt. However, child/youth/young adult is able to function on a daily basis in developmentally expected ways.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult. Examples of such parenting practices include but are not limited to the following:

- Caregiver is unable or unwilling to protect the child/youth/young adult from harm by another.

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

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- Caregiver has not set limits/expectations for the child/youth/young adult to the extent that the child/youth/young adult has no sense of commonly acceptable behavior and no ability to manage his/her own behavior; child/youth/young adult has already or is likely to engage in delinquent behaviors.

- Caregiver is unaware of the child/youth/young adult's needs to the extent that the child/youth/young adult has become seriously ill or injured due to unmet basic needs.

- Caregiver rarely, if ever, expresses love or value for the child/youth/young adult AND the child/youth/young adult is showing signs of emotional harm. Symptoms of emotional harm to the child/youth/young adult 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 *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnoses related to experiences of caregiver behavior.

SN4. Social Support System

A social support system is a network of individuals (other than intimate partners or members of the household) or organizations (e.g., religious organizations, community organizations, professional providers) who provide or share concrete support (e.g., financial help, transportation, babysitting) or emotional support (e.g., listening, advice). Contact may include in-person or other means, including social media.

<u>The caregiver's social support system</u>:

a. <u>Actively helps create safety, permanency, and child/youth/young adult well-being</u>. The caregiver has frequent contact with an extensive mutual support system. A mutual support system means that the caregiver is able to engage in providing support to members of his/her support network and is able to access support from members when needed.

   AND

   This contributes to child/youth/young adult safety in that many people work together to create safety for the child/youth/young adult.

b. <u>Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being</u>. The caregiver has a sufficient social support system and is able to get concrete or emotional support when needed.

   OR

   The caregiver is able to maintain child/youth/young adult safety despite lack of social support.

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c. Is a barrier to safety, permanency, or child/youth/young adult well-being. At times, the caregiver needs concrete or emotional support and his/her social support system is not able to provide what the caregiver needs. As a result, the child/youth/young adult experiences some isolation or unmet needs; however, this has not created danger for the child/youth/young adult. This may include:

- Lack of a sufficient social support system;
- Not using the support that is available; and/or
- The support provided either contributes to child/youth/young adult distress or adversely impairs the caregiver's ability to create long-term safety.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult. The caregiver is unable to resolve conditions that create danger for the child/youth/young adult because of limits in the ability of his/her social support network to help in ways that would keep the child/youth/young adult safe. This may include the following:

- No one is able to help provide concrete support that is needed, and this has contributed to danger (e.g., needed medical care for child/youth/young adult is not sought due to lack of transportation).
- The caregiver's lack of support contributes to the caregiver's experience of being overwhelmed and as a result, the caregiver cannot meet the needs of the child/youth/young adult, which has resulted in danger (e.g., caregiver cannot get respite care and as a result either leaves child/youth/young adult unattended in a dangerous situation or stays with child/youth/young adult but loses control and hurts child/youth/young adult).
- Involvement of the social support system directly creates danger for the child/youth/young adult (e.g., while providing concrete support, system member encourages caregiver to use drugs).

SN5. Household and Family Relationships

Include relationships between caregiver and other adults in the household, including intimate relationships, but do not rate presence or absence of physical violence or intimidating/controlling behaviors in this item.

The caregiver's relationships with other adult household members:

a. Actively help create safety, permanency, and child/youth/young adult well-being. Caregiver and other adult household members have and demonstrate healthy interpersonal relationships, including communication, shared agreements, mutual respect, empathy, and safe conflict resolution.

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b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being. Caregiver and other household members have relationships that do not adversely affect child/youth/young adult.

c. Are barriers to safety, permanency, or child/youth/young adult well-being. Caregiver and other household members or child/youth/young adult's other parent experience conflict to the extent that child/youth/young adult is aware of and troubled by conflict.

OR

Child/youth/young adult is confused and/or upset by frequent introduction of new intimate partners of the caregiver.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult. Conflict among adult household members is so persistent and severe that child/youth/young adult's needs are unmet to the extent that the child/youth/young adult has been seriously harmed or is in danger of being seriously harmed.

OR

Caregiver allows individuals who are violent or sexual toward the child/youth/young adult to be part of the household.

OR

Caregiver's relationship with child/youth/young adult's other parent(s) continues to involve child/youth/young adult in conflict to the extent that child/youth/young adult is seriously emotionally harmed and/or caused to experience repeated medical/legal examinations due to repeated unfounded allegations against the other parent.

SN6. Domestic Violence

Household violence means physical violence or a pattern of threats/intimidation or controlling behavior between the caregiver and any adult household member, including intimate relationships. This does not include violence between a caregiver and a minor child/youth/young adult.

The caregiver's intimate relationships:

a. Actively help create safety, permanency, and child/youth/young adult well-being. The caregiver consistently responds nonviolently to situations involving conflict and frustration and works with other adults in the household to make choices.

AND

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This contributes to safety for the child/youth/young adult by effectively protecting the child/youth/young adult from violence and teaching/demonstrating nonviolence to the child/youth/young adult.

The caregiver may have a history of violent relationships, but he/she has developed new patterns of behavior and consciously chooses relationships that are not violent.

b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being. The caregiver is not currently in and has not been in a relationship that includes violence, threats/intimidation, or controlling behavior.

OR

The caregiver is or has been in a relationship that includes a minimal degree of violence, threats/intimidation, or controlling behavior, but the child/youth/young adult is unaware and/or untroubled AND has not experienced harm.

Violence that has resulted in injury to a caregiver or involved use of a weapon cannot be rated "b" even if the child/youth/young adult is unaware or reports being unaffected.

c. Are barriers to safety, permanency, or child/youth/young adult well-being. The caregiver is in or has been in a relationship characterized by violence or a pattern of threats/intimidation or controlling behavior, and the child/youth/young adult is aware of and troubled by this.

OR

The violence, threats/intimidation, or controlling behavior is ongoing and increasing in frequency or severity.

OR

The caregiver has ended a violent relationship but has not developed behaviors to prevent repeating being either a victim or an aggressor.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult. The caregiver is in or has recently left a relationship characterized by severe household violence and the child/youth/young adult has been seriously hurt, physically or emotionally, by the violence.

OR

The caregiver remains in a violent relationship and at least one partner is unwilling to address the violence.

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SN7. Substance Use

Include alcohol, other illegal drugs, and prescription drugs that are not used according to prescription.

The caregiver's actions regarding substance use:

a. Actively help create safety, permanency, and child/youth/young adult well-being. The caregiver has no history of substance abuse (whether or not caregiver uses alcohol or legal drugs) OR the caregiver may have a history of substance abuse but is in recovery to the extent that he/she helps support the recovery of others;

AND

The caregiver, by words and actions, actively promotes a healthy, addiction-free lifestyle and environment for his/her children.

b. Are not a strength or barrier for safety, permanency, or child/youth/young adult well-being. The caregiver has no history of substance abuse (whether or not caregiver uses alcohol or legal drugs) OR has a history of substance abuse but is in recovery and able to maintain recovery without formal support (may continue to participate in self-help groups);

HOWEVER

Alcohol and drug use or history of use does not negatively affect parenting or the caregiver's ability to maintain child/youth/young adult safety.

c. Are a barrier to safety, permanency, or child/youth/young adult well-being. The caregiver's alcohol or drug use results in behaviors that impede his/her ability to meet the child/youth/young adult's basic needs (food, clothing, shelter, supervision, and hygiene) or emotional well-being on a consistent basis and/or have contributed to a current, nondangerous incident;
OR

The caregiver is in recovery from drug or alcohol abuse and requires minimal to moderate continuing support to preserve child/youth/young adult safety, e.g., caregiver remains in day treatment or other outpatient intervention;

HOWEVER

Caregiver's alcohol or drug use has not resulted in serious harm to the child/youth/young adult (e.g., malnutrition, homelessness, physical harm due to insufficient supervision).

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult. The caregiver's use of alcohol or drugs results in behaviors that consistently impede his/her ability to meet the child/youth/young adult's basic

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needs to the extent that the child/youth/young adult has been seriously harmed by abuse or neglect, or serious harm is imminent.

OR

Caregiver is just beginning recovery and needs intensive support to preserve child/youth/young adult safety, e.g., caregiver is in detox or inpatient treatment or residential setting to support recovery.

AND

- Caregiver is physically or attentively absent to the extent that child/youth/young adult is in danger.
- When caregiver is under the influence of alcohol or drugs, he/she forgets to feed the child/youth/young adult to the extent that the child/youth/young adult has experienced growth disruption, malnutrition, or dehydration.
- When caregiver is under the influence of alcohol or drugs, he/she becomes violent toward or near the child/youth/young adult.

SN8. Mental Health

Mental health includes a diagnosed condition (which is not automatically a need) and also 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/youth/young adult. Similarly, a caregiver with exceptional coping skills may be able to parent and protect the child/youth/young adult through extraordinarily stressful family conditions.

When assessing the caregiver's mental health and coping skills, consider whether the caregiver has any diagnosed or suspected mental health conditions AND whether these conditions affect the caregiver's ability to parent and protect the child/youth/young adult.

<u>The caregiver's mental health</u>:

a. <u>Actively helps create safety, permanency, and child/youth/young adult well-being</u>. 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 his/her 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 the child/youth/young adult needs, and caregiver has/acquires the knowledge needed to respond to child/youth/young adult's needs most of the time.

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b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being. Caregiver may struggle from time to time, but caregiver is always able to manage sufficiently so that child/youth/young adult does not experience significant stress, worry, or unmet needs. For example, caregiver may experience some depression or anxiety, but he/she is managing through medication, therapy, or self-help so that while child/youth/young adult may be aware, child/youth/young adult is not significantly worried and the caregiver's condition does not interfere with caregiving.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being. Examples of caregiver behavior include but are not limited to the following:

- 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 the child/youth/young adult's needs, the caregiver is able to rally and continue.

Examples of impact on the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may occasionally worry about how caregiver is coping, but such worry does not interfere with his/her participation in school or community life.

- Child/youth/young adult may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.

- Child/youth/young adult may have a periodic sense of loss/grief when caregiver is not available.

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

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult. 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 disorder, schizophrenia, suicidal ideation, 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.

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- Caregiver has been repeatedly hospitalized for mental health concerns.

Examples of threats of serious harm to the child/youth/young adult include but are not limited to the following:

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

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

- Child/youth/young adult is falling significantly behind developmentally due to prolonged caregiver unavailability/absence.

- Caregiver could not meet child/youth/young adult's needs for food, shelter, or supervision to the extent that it was dangerous.

SN9. Prior Adverse Experiences/Trauma

Trauma may occur when a person has experienced, witnessed, or been confronted with an event(s) of actual or threatened death or serious injury, a threat of serious physical harm to him/herself or others, or emotional abuse. 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.

<u>The caregiver's response to prior adverse experiences/trauma</u>:

a. <u>Actively helps create safety, permanency, and child/youth/young adult well-being</u>. Caregiver has not experienced trauma OR the caregiver has a prior experience of trauma, but that prior trauma provides the caregiver with additional skills to improve daily functioning.

b. <u>Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being</u>. The caregiver may or may not have a prior history of trauma; however, any traumatic experiences do not impact care for the child/youth/young adult (either because there is no impact on the caregiver's functioning or because the caregiver has learned to manage the impact on his/her functioning effectively).

c. <u>Is a barrier to safety, permanency, or child/youth/young adult well-being</u>. 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/youth/young adult. 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; has distressing dreams of the event; or acts or feels like the traumatic event is recurring, BUT caregiver has learned some skills and interventions to manage these thoughts and caregiver sometimes uses them.

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d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult. 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/youth/young adult. For example, the caregiver has not accessed services and/or cannot use coping strategies or has not received intervention to help manage his/her responses, AND this has resulted in significant harm to the child/youth/young adult. Caregiver may deny the traumatic experience or how it affects him/her or the child/youth/young adult.

SN10. Cognitive/Developmental Abilities

Include diagnosed or suspected cognitive conditions, including developmental disabilities, traumatic brain injury, or dementia/Alzheimer's disease. When assessing, consider both the diagnosed or suspected condition AND the impact that such conditions have on the caregiver's ability to adequately parent and protect the child/youth/young adult. The condition itself does not necessitate the selection of "d."

The caregiver's developmental and cognitive abilities:

a. Actively help create safety, permanency, and child/youth/young adult well-being. Caregiver demonstrates ability to think about what child/youth/young adult needs and has or acquires the knowledge needed to respond to child/youth/young adult's needs. Caregiver has demonstrated creative thinking to overcome challenges and has created child/youth/young adult safety as a result.

b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being. Caregiver has no cognitive limitations;

OR

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

c. Are barriers to safety, permanency, or child/youth/young adult well-being. Examples of caregiver behavior include but are not limited to the following:

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

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- 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 the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may occasionally worry about how caregiver is coping, but such worry does not interfere with participation in school or community life.

- Child/youth/young adult may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.

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

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult. Examples of parental behaviors or conditions include but are not limited to the following:

- Caregiver has significant difficulty understanding fundamental parenting information, such as how much to feed and how often, how to decide when a child/youth/young adult needs medical care, or whether it is reasonable to expect a 6-month-old to be fully potty-trained. Despite numerous efforts to help the caregiver understand vital information, he/she does not appear to comprehend and cannot apply information to parenting tasks.

Examples of threats of serious harm to the child/youth/young adult include but are not limited to the following:

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

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

- Caregiver cannot meet child/youth/young adult's needs for food, shelter, or supervision.

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SN11. Other Identified Caregiver Strength or Need (not covered in SN1–SN10)

Mark "not applicable" if the caregiver does not have any strengths or needs that are relevant for case planning, beyond those captured in the domains above.

OR

An additional need or strength has been identified that:

a. Actively helps create safety, permanency, and child/youth/young adult well-being. A caregiver has 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 areas of need.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being. A caregiver has an area of strength or need that is not included in other domains, but this area is not relevant for case planning.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being. A caregiver's need has a moderate to significant impact on family functioning but has not resulted in harm or threat of harm to the child/youth/young adult. The family perceives that they would benefit from services and support that address the need.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult. A caregiver has a need that has a serious impact on family functioning, placing the child/youth/young adult at imminent threat of serious harm.

SECTION 2: CHILD/YOUTH/YOUNG ADULT STRENGTHS AND NEEDS ASSESSMENT

A. Household Context

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 a family member's race (African American/Black, American Indian/Alaska Native, Asian/Pacific Islander, Latino/a, multiracial, White, other), ethnicity, tribal affiliation, sexual orientation (heterosexual, gay, lesbian, bisexual), gender identity/expression (female, male, transgender, other), religious/spiritual affiliation, disability, or other social identity that reflects the family's unique characteristics.*

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 a family member 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.

Connecting culture and identity

Consider how the family's culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence or shape the child/youth/young adult's perspective. In particular, consider:

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

How do all of the above influence or shape the child/youth/young adult?

The child/youth/young adult's perspective of culture, cultural identity, norms, and past/current experiences of discrimination:

a. Help him/her create safety, permanency, and well-being for him/herself. The child/youth/young adult draws upon his/her culture to respond to challenges in ways that create safety for the child/youth/young adult.

b. Have no effect on his/her safety, permanency, or well-being. The child/youth/young adult is connected to a culture and/or identifies with a culture and this has no impact on his/her safety.

c. Make it difficult for him/her to experience long-term safety, permanency, or well-being. The child/youth/young adult is connected to a culture and/or identifies with a culture in ways that cause struggles, such as mild to moderate conflict with the caregiver over culture/cultural identity or disrupted relationships with the caregiver based on cultural differences.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult. The child/youth/young adult is connected to a culture and/or identifies with a culture in ways that cause danger for the child/youth/young adult, such as physically or emotionally harming him/herself over differences in culture/cultural identity.

B. Child/Youth/Young Adult Domains

CSN1. Emotional/Behavioral Health

a. The child/youth/young adult's emotional/behavioral health contributes to his/her safety. The child/youth/young adult displays coping skills/responses at or above the developmentally expected ability in dealing with crises, disappointment, and daily challenges and contributes to his/her own safety.

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The child/youth/young adult routinely manages his/her own behavior at or above developmentally expected ability.

The child/youth/young adult is developing a sense of acceptable social norms valued by his/her family and/or community, and the child/youth/young adult is able to weigh the positives and negatives of conforming to or deviating from such norms.

b. The child/youth/young adult does not have an emotional/behavioral concern OR the child/youth/young adult has an emotional/behavioral health concern, but no additional intervention is needed. The child/youth/young adult's coping skills/responses do not interfere with school, family, or community functioning. The child/youth/young adult is able to develop and maintain trusting relationships. The child/youth/young adult may be able to identify the need for, seek, and accept guidance. The child/youth/young adult may demonstrate some situationally related depression, anxiety, or withdrawal symptoms. However, the child/youth/young adult maintains situationally appropriate emotional control.

OR

The child/youth/young adult has emotional or behavioral health concerns that are being effectively managed through a treatment program that does not require additional caregiver support (e.g., child/youth/young adult receives limited in-school support and is not on medication).

c. The child/youth/young adult has an emotional/behavioral health concern, AND it is an ongoing unmet need. The child/youth/young adult must display one of the following:

- Periodic mental health symptoms (e.g., depression, somatic complaints, antisocial behavior, hostile behavior, apathy).

  OR

- Some difficulties dealing with situational stress, crises, or problems.

AND one of the following must also be true.

- This is interfering with the child/youth/young adult's sense of well-being, development, and/or ability to form relationships.

  OR

- The child/youth/young adult's emotional or behavioral health condition is being managed through a treatment program that requires minimal to moderate caregiver support.

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d. The child/youth/young adult has an emotional/behavioral health concern that directly contributes to danger to the child/youth/young adult. The child/youth/young adult must display one of the following:

- Functioning in one or more areas is severely impaired due to chronic/severe mental health symptoms.

  OR

- Behavior is/may be harmful to self or others, including self-injury, extreme risk-taking, persistent violence toward others, inappropriate sexual behaviors, cruelty to animals, running away, curfew violations, stealing, inappropriate use of social media (e.g., sexting, cyberbullying), defiant behaviors, truancy, or fire-setting.

AND one of the following must be true.

- The child/youth/young adult is in danger of serious harm to self or others.

  OR

- The child/youth/young adult's emotional or behavioral condition is being managed through a treatment program that requires extensive caregiver support and/or frequent crisis intervention.

CSN2. Trauma

Trauma may occur when a person has experienced, witnessed, or been confronted with an event(s) of actual or threatened death or serious injury, or a threat of serious physical harm to him/herself 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.

a. The child/youth/young adult's response to prior trauma contributes to his/her safety. The child/youth/young adult has a prior experience of trauma, but that prior trauma provides the child/youth/young adult with additional skills to improve daily functioning.

b. The child/youth/young adult has not experienced trauma OR the child/youth/young adult has experienced trauma but no additional intervention is needed. The child/youth/young adult may or may not have a prior history of trauma; however, any traumatic experiences do not impact care for the child/youth/young adult, either because there is no impact on the child/youth/young adult's functioning or because the child/youth/young adult has learned to manage the impact on his/her functioning effectively.

c. The child/youth/young adult's response to prior trauma is a concern AND it is an ongoing unmet need. The child/youth/young adult has experienced trauma AND the child/youth/young adult's response involved intense fear, helplessness, or

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horror that sometimes impairs his/her functioning and sometimes causes distress. He/she does not have long-term indicators of permanent harm/distress but could learn to manage the impacts of trauma on his/her functioning, or he/she has begun to learn to apply some strategies to manage these responses and sometimes uses them.

d. The child/youth/young adult's response to prior trauma is a concern that directly contributes to danger to the child/youth/young adult. The child/youth/young adult has experienced trauma AND the child/youth/young adult's response involved intense fear, helplessness, or horror, causing impaired functioning and significant distress/harm for the child/youth/young adult. For example, the child/youth/young adult has not accessed services, cannot use coping strategies, and/or has not received intervention to help manage his/her responses, AND this has resulted in significant harm to the child/youth/young adult. The child/youth/young adult may deny the traumatic experience or how it is affecting him/her.

CSN3. Child Development

For a chart of average development by age, consult pages 126–128 of this manual.

a. The child/youth/young adult's development is advanced. The child/youth/young adult's physical and cognitive skills are above his/her chronological age level.

b. The child/youth/young adult's development is age-appropriate. The child/youth/young adult's physical and cognitive skills are consistent with his/her chronological age level.

c. The child/youth/young adult's development is limited. The child/youth/young adult does not exhibit most physical and cognitive skills expected for his/her chronological age level.

d. The child/youth/young adult's development is severely limited. Most of the child/youth/young adult's physical and cognitive skills are two or more age or developmental levels behind chronological age expectations. If "d" is selected, also indicate whether a regional center referral has been completed.

CSN4. Education

a. The child/youth/young adult has outstanding academic achievement. The child/youth/young adult is working above grade level and/or is exceeding the expectations of the specific educational plan.

b. The child/youth/young adult has satisfactory academic achievement OR the child/youth/young adult is not of school age. The child/youth/young adult is working at grade level and/or is meeting the expectations of the specific educational plan, or the child/youth/young adult is not of school age.

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c. The child/youth/young adult has academic difficulty. The child/youth/young adult is working below grade level in at least one, but not more than half, of his/her academic subject areas, and/or the child/youth/young adult is struggling to meet the goals of the existing educational plan. The existing educational plan may need modification.

d. The child/youth/young adult has severe academic difficulty. The child/youth/young adult is working below grade level in more than half of his/her academic subject areas, and/or the child/youth/young adult is not meeting the goals of the existing educational plan. The existing educational plan needs modification.

CSN5. Social Relationships

When considering adult relationships, consider the child/youth/young adult's relationships with adults who are not immediate family members or foster family members. This domain would include coaches, neighbors, child welfare workers, club leaders, teachers, mentors, etc. Specify in the narrative who these adults are.

When considering peer relationships, consider the child/youth/young adult's relationships with other children in school and the community. Exclude relationships with siblings.

a. The child/youth/young adult has strong social relationships. The child/youth/young adult enjoys and participates in a variety of constructive, age-appropriate social activities. The child/youth/young adult enjoys reciprocal, positive relationships with others.

b. The child/youth/young adult has adequate social relationships. The child/youth/young adult demonstrates adequate social skills. The child/youth/young adult maintains stable relationships with others; occasional conflicts are minor and easily resolved.

c. The child/youth/young adult has limited social relationships. The child/youth/young adult demonstrates inconsistent social skills and has limited positive interactions with others. Conflicts are more frequent and serious, and the child/youth/young adult may be unable to resolve them.

d. The child/youth/young adult has poor social relationships. The child/youth/young adult has poor social skills, as demonstrated by frequent conflictual relationships or exclusive interactions with negative or exploitative peers, or the child/youth/young adult is isolated and lacks a support system.

CSN6. Family Relationships

For children in voluntary or court-ordered placement, score the child/youth/young adult's family of origin, not his/her placement family.

a. The child/youth/young adult's relationships within his/her family contribute to his/her safety. The child/youth/young adult experiences positive interactions with family members and has a sense of belonging within the family. The family defines

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roles, has clear boundaries, and supports the child/youth/young adult's growth and development.

b. The child/youth/young adult's relationships within his/her family do not impact his/her safety. The child/youth/young adult experiences positive interactions with family members and feels safe and secure in the family, despite some unresolved family conflicts.

c. The child/youth/young adult's relationships within his/her family interfere with long-term safety. Stress/discord within the family interferes with the child/youth/young adult's sense of safety and security. The family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own.

d. The child/youth/young adult's relationships within his/her family contribute to danger of serious physical or emotional harm to the child/youth/young adult. Chronic family stress, conflict, or violence severely impedes the child/youth/young adult's sense of safety and security. The family is unable to resolve stress, conflict, or violence on their own and is not able or willing to obtain outside assistance.

CSN7. Physical Health/Disability

Physical health means physical well-being, which includes dental and vision care. Also indicate whether the child/youth/young adult's immunizations are current.

a. The child/youth/young adult has no health care needs or disabilities. The child/youth/young adult demonstrates good health and hygiene care, involving awareness of nutrition and exercise. The child/youth/young adult receives routine preventive and medical/dental/vision care and immunization.

b. The child/youth/young adult has minor health problems or disabilities that are being addressed with minimal intervention and/or medication. The child/youth/young adult has adequate health. Minimal interventions are those that typically require no formal training (e.g., oral medications).

c. The child/youth/young adult has health care needs or disabilities that require routine interventions. The child/youth/young adult has minor health/disability needs. Routine interventions are those that are typically provided by lay persons after minimal instruction (e.g., glucose testing and insulin, cast care).

d. The child/youth/young adult has serious health/disability needs that require ongoing treatment and interventions by professionals or trained caregivers AND/OR the child/youth/young adult has an unmet medical need. Those who provide treatment/interventions have received substantial instruction (e.g., central line feeding, paraplegic care, or wound dressing changes).

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CSN8. Alcohol/Drugs

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

a. The child/youth/young adult actively chooses an alcohol- and drug-free lifestyle. The child/youth/young adult does not use alcohol or other drugs and is aware of consequences of use. The child/youth/young adult avoids peer relations/social activities involving alcohol and other drugs, and/or chooses not to use substances despite peer pressure/opportunities to do so.

b. The child/youth/young adult does not use or experiment with alcohol/drugs. The child/youth/young adult does not use alcohol or other drugs. The child/youth/young adult may have experimented with alcohol or other drugs, but there is no indication of sustained use. The child/youth/young adult has no demonstrated history or current problems related to substance use.

c. The child/youth/young adult's alcohol and/or other drug use results in disruptive behavior and conflict. This conflict may occur in school/community/family/work relationships. Use may have broadened to include multiple drugs.

d. The child/youth/young adult's chronic alcohol and/or other drug use results in severe disruption of functioning. Disruption of functioning may be indicated by the loss of relationships or jobs, school suspension/expulsion/drop-out, problems with the law, and/or physical harm to self or others. The child/youth/young adult may require medical intervention to detoxify.

CSN9. Delinquency

Delinquent behavior includes any action that would constitute a crime. Consider this domain to include both offenses for which the child/youth/young adult has been arrested/charged and those which have not yet come to the attention of law enforcement.

a. The child/youth/young adult has no delinquent behavior. There is no indication of delinquent history or behavior. The child/youth/young adult may be involved in community service and/or crime prevention programs and takes a stance against crime.

b. The child/youth/young adult has no criminal behavior in the past two years. There is a history of delinquent behavior but the child/youth/young adult has successfully completed probation, and there has been no criminal behavior in the past two years.

c. The child/youth/young adult is/has engaged in delinquent behavior and may have been arrested or placed on probation in the past two years. The child/youth/young adult may have been arrested or placed on probation within the past two years.

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d. The child/youth/young adult is or has been involved in any violent, or repeated nonviolent, delinquent behavior. This behavior has or may have resulted in consequences such as arrests, incarcerations, or probation. Violent behavior includes aggressive behavior in any form that has resulted or is likely to result in an injury to another person. Repeated nonviolent delinquent behavior includes situations where a youth has more than one contact for delinquent behavior, but none of the contacts included violent behavior, as defined above.

CSN10. Relationship With Substitute Care Provider (if child/youth/young adult is in care)

Consider the wishes and feelings of the child/youth/young adult as appropriate. Indicate whether the wishes and feelings of the child/youth/young adult assist in the development of strengths or create struggles for the child/youth/young adult.

When assessing this item, keep in mind that the child/youth/young adult may have different relationships with adults and with children in the home. Please consider both when documenting strengths and struggles.

Not applicable; child/youth/young adult is not in care.

a. The child/youth/young adult has developed a healthy attachment to at least one substitute care provider. The child/youth/young adult has developed a nurturing/supportive relationship with at least one substitute care provider. There is positive interaction/attachment between the child/youth/young adult and caregiver or others in the caregiver's household; the child/youth/young adult is supported and has a sense of belonging.

b. The child/youth/young adult has no conflicts with the substitute care provider. Adequate relationships exist with all family members. Interactions between the child/youth/young adult and substitute care provider (and others in the caregiver's household) are generally positive; age-appropriate attachments exist despite some problems.

c. The child/youth/young adult has some conflicts with the substitute care provider that have resulted or may result in the child/youth/young adult feeling unsafe or unaccepted in the placement; however, with support, these issues can be mitigated. The child/youth/young adult has limited relationships with the substitute care provider and family members. Problems limit positive interactions and appropriate attachments with one or more members of the substitute care provider's household.

d. The child/youth/young adult has serious conflicts with one or more members of the current substitute care provider's household. There are significant problems/conflict in the placement. Chronic problems severely interfere with the child/youth/young adult's interactions and attachments with one or more members of the substitute care provider's household.

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CSN11. Independent Living (if age 15.5 or older)

Includes:

- Financial knowledge (e.g., 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 (e.g., hygiene, laundry, housekeeping, grocery shopping, cooking, basic health care, etc.).

a. The youth/young adult is prepared to function as an adult. The youth/young adult has demonstrated and practiced skills necessary for independent living and is prepared.

b. The youth/young adult is making progress toward being prepared for adulthood. The youth/young adult has had an opportunity to demonstrate and/or practice the skills included in independent living. It may be considered a strength if the youth/young adult is aware that he/she is not fully prepared but is making progress. Youth/young adult is participating in formal or informal independent living services.

c. The youth/young adult is attempting to prepare for adulthood but lacks the confidence, emotional maturity, and/or sufficient skills to live independently. The youth/young adult may have developed only some or none of the skills necessary for independent living. The youth/young adult may be fully confident of his/her ability to live independently, contrary to his/her actual skills/abilities (e.g., youth/young adult may be delaying completion of tasks to receive an extension; youth/young adult may lack a support system to provide advice after aging out).

d. The youth/young adult is not prepared or is refusing to prepare for adulthood. The youth/young adult is actively not participating in plans for preparation for adulthood or is unable to prepare in key areas that may include but are not limited to the following:

    - Youth/young adult has sex offense charges and is ineligible for federal housing programs.
    - Youth/young adult is in an out-of-state facility where independent living planning is impeded.
    - Youth/young adult has developmental delays that impede independent functioning.

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For youth/young adults age 15.5 and older, check all that apply to preparation for adulthood.

- The youth/young adult is receiving assistance from a regional center.
- The 15.5-year-old assessment has been completed.
- For youth/young adults age 16 or older, a referral to formal services and a credit check application have been completed.
- For youth/young adults age 17 and older, an independent living plan has been completed.
- An exit plan meeting has been held.
- An exit from foster care meeting has been held.
- The youth/young adult is participating in the extension foster care program (AB 12).

CSN12. Other Identified Child/Youth/Young Adult Strength or Need (not covered in CSN1–CSN11)

Mark "not applicable" if the caregiver does not have any strengths or needs that are relevant for case planning, beyond those captured in the domains above.

OR

An additional need or strength has been identified that:

a. Actively helps him/her create safety, permanency, and well-being for him/herself. A child/youth/young adult has 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.

b. Is not a strength or barrier for his/her safety, permanency, or well-being. A child/youth/young adult has an area of strength or need that is not included in other domains, but this area is not relevant for case planning.

c. Is a barrier to his/her safety, permanency, or well-being. A child/youth/young adult has a need that has a moderate impact on family functioning. The family perceives that they would benefit from services and support that address the need.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult. A child/youth/young adult has a serious need that has a significant impact on family functioning.

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CALIFORNIA
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT
(FOR CAREGIVERS AND CHILDREN)
POLICY AND PROCEDURES

The family strengths and needs assessment (FSNA) is used to evaluate the presenting strengths and barriers that caregivers encounter when trying to provide safety, permanency, and well-being for their children. This assessment is used with caregivers to collaboratively identify critical family needs that should be addressed in the case plan. This tool is used to systematically identify critical family needs that underlie safety in the family and risk of subsequent harm, and it helps plan effective interventions with the family. The FSNA serves several purposes:

- It ensures that all social workers consistently consider each family's strengths and needs in an objective format when assessing the need for interventions that improve child/youth outcomes.
- It provides an guide to support collaborative assessment for development of case plans by workers, supervisors, and family members that assists in identifying key areas of need and strengths and resources that can be used to increase child/youth safety.
- The initial strengths and needs assessment, when followed by periodic reassessments, permits family members, social workers, family support workers, and their supervisors to assess changes in family functioning together and thus assess the effects of their work together over time during the case plan service period.
- In the aggregate, needs assessment data provide management with information on the problems families face. These profiles can then be used to develop resources to meet family needs.

Which Cases: Every referral that is promoted to a case.

May be used when a referral will be closed and a detailed service referral will be made, which may benefit from the completion of an FSNA.

The child assessment portion is completed for each child who will be included in the case plan and for whom a case is established in the child welfare services case management system (CWS/CMS).

Who: The social worker who is responsible for developing the initial case plan in conjunction with the family.

When: Initial: Prior to initial case plan
Review: Voluntary—within 30 days prior to case plan
Court—within 65 days prior to case plan

Decision: Identifies the priority needs of caregivers and all needs of children that must be addressed in the case plan. Goals, objectives, and interventions in a case plan should relate to one or more of the priority needs.

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Identifies a family's priority areas of strength, which should be incorporated into the case plan to the greatest extent possible, as a means to address identified needs.

Appropriate Completion

Workers should familiarize themselves with the 11 caregiver domains and the 12 child domains of the FSNA and the corresponding definitions. Workers will notice that the domains are areas that they began to look at in the assessments prior to the FSNA, with the difference that the responses to these items lead to specific case planning goals and objectives.

Once a worker is familiar with the domains that must be assessed to complete the FSNA, the worker should conduct his/her family assessment as he/she normally would—using good social work practice to collect information from the child, caregiver, and/or collateral sources.

Each of the domains in the assessment represents a significant area of family functioning that may support or impede a family's ability to maintain the safety, permanency, 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 his/her ability to effectively provide for the safety of the child/youth/young adult.

For each domain, there are four possible responses:

a. This is a strength response where the behavior actively helps create safety, permanency, and child/youth/young adult well-being.

b. This is an "average" or adequate functioning response. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

   This response is also used to score children who are too young to assess in some categories. A caregiver/child with a response of "b" has not achieved the exceptional skills or resources reflected by a response of "a" and may experience a degree of stress or struggle common to daily functioning, but is generally functioning well in the area. These responses are considered as potential strengths, with the exception of children who are scored "b" in some categories because they are too young to assess. For example, an infant may be scored "b" for delinquency because he/she is too young to be assessed in this area, but it should not be selected as a strength for case planning purposes.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being. A response in this area may be a barrier to achieving child safety, permanency, or well-being but does not actively contribute to a threat to a child's safety.

d. A response in this category represents an area that actively contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

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When scoring, consider the entire scope of available information, including the family's perspective, information from collateral sources, existing records and documents, and worker observations. Often, different sources will suggest different responses (e.g., father states he has no problem with alcohol, but has had two DUIs in the last year; mother states she believes he is an alcoholic; a court-ordered AOD assessment suggests alcohol dependency; father's brother states father has no problem with alcohol). The worker must make a determination based on social work assessment skills, taking into account the merits of each perspective. The household is assessed by completing all domains. If there are two caregivers, each is assessed and scored separately.

SN1 to SN11 and CSN1 to CSN12

Determine the appropriate response for each domain and check the item in the space provided. Note that:

- CSN1 to CSN10 relate to children in the family/household.
- CSN10 is only answered for a child in placement and addresses the child's relationship to his/her substitute care provider.
- CSN11 is only answered for a young person who is at least 15.5 years old and addresses independent living issues.
- SN11 and CSN12 are used when a caregiver or child, respectively, has a unique strength, barrier, or critical need that contributes to imminent danger that is not covered in other domains and is relevant to case planning. If an individual has a strength, mark "a." If an individual has an area of strength or need that is not covered in other domains but it is not relevant for case planning, mark "b." If an individual has a need, mark "c" or "d," depending on the severity of the need. Use the comment box to briefly describe "a," "c," or "d" responses.

Priority Needs and Strengths for Caregivers and Children

To identify priority strengths and needs for caregivers, consider ratings for domains SN1 through SN11 in Section 1 (caregiver) of the FSNA. All identified child needs must be considered in the family case plan.

All domains identified as "d" (contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult) should have a danger statement created about them and be addressed both by a safety plan and by the case plan. These are priorities for case closure.

All items entered as "c" (a barrier to safety, permanency, or child/youth/young adult well-being) should be strongly considered for the case plan but may not be required to be fully resolved for case closure.

All items entered as "a" should be considered as potential resources and aids when addressing domains identified as "d" and "c."

For needs, enter the domain number and title for all domains assessed as a contributor to imminent danger ("d") first and then all domains assessed as a barrier ("c"). A domain may be a priority need for

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one or both caregivers. Identify whether the assessment of each domain is for the primary caregiver, secondary caregiver, or both (P, S, or B).

For priority strengths, enter the domain number and title of all domains with an assessment of "a" (actively helps create safety, permanency, and child/youth/young adult well-being). Only items with an "a" may be identified as priority strengths. Look across both caregivers to identify strengths. A domain may be a priority strength for one or both caregivers. Mark "P" if it is a strength for only the primary caregiver, "S" if it is a strength for only the secondary caregiver, and "B" if it is a strength for both the primary and secondary caregivers.

Note: A domain may be a priority need for one caregiver and a priority strength for another caregiver.

Case Plan

A family case plan is to be written with behaviorally specific goals and objectives that consider and incorporate the caregiver's priority strengths in addressing the caregiver's priority needs. The family case plan is also to include service referrals that address the child's needs and take into consideration the child's strengths. It is the caregiver's responsibility to ensure that the child's needs are met through appropriate service provision. If a child is in protective placement, and the caregiver is unable to meet the child's needs, the agency must meet the child's needs.

Practice Considerations

Completion of the FSNA requires gathering information from all family members and collaterals, and performing a review of records. The assessment may be completed or modified during the course of family team meetings. The worker must be aware of culturally specific interpretation of appearances and must engage the family in culturally appropriate ways to make an accurate assessment. Where it is difficult to distinguish between responses, additional assessment may be helpful (i.e., psychological, developmental, substance use assessments), particularly if the difference between one rating and another is likely to impact the selection of priority needs.

The FSNA identifies priority AREAS to address in the case plan. Once those areas are identified, the worker may benefit from additional assessment within those areas to identify specific objectives, services, and activities most appropriate for this family. The family's history of service utilization and willingness to change in these areas should be considered. Case plan objectives should be behaviorally specific-and measurable. If there was a safety plan in place, any continuing safety intervention requirements should now be incorporated into the case plan.

Once completed, the initial assessment and the resulting case plan can be used as a foundation for ongoing conversations and periodic (monthly) assessment between the social workers and family members about progress in identified areas of need and use of identified strengths and resources to increase child/youth/young adult safety, permanency, and well-being. This ongoing assessment process, documented in the case record during the service period, then serves to inform formal reassessment tools.

For children in out-of-home care, the case plan will also include information regarding visitation. While SDM does not guide the decision concerning visitation in the initial case plan, the worker is encouraged to consider the safety threats that led to removal, the risk level, and the specific needs of parent and child.

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Physical and Cognitive Developmental Milestones		
Age Level	**Physical Skills**	**Cognitive Skills**
0 to 1 Year		
0 to 4 weeks	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.	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, in pain).
1 to 3 months	Head to 45 degrees when on abdomen, erect when sitting. Bears fraction of weight when held in standing position. Uses vocalizations. By 2 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.	Increased babbles and coos. Most laugh out loud, squeal, and giggle. Smiles responsively to human face. Increases attention span.
3 to 6 months	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.	Spontaneously vocalizes vowels, consonants, a few syllables. Responds to tone and inflection of voice. Smiles at image in mirror.
6 to 9 months	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 9 months, pulls self to standing.	Says mama/dada randomly. Begins to imitate speech sounds. Many syllable sounds (ma, ba, da). Responds to own name, beginning responsiveness to "no, no."
9 to 12 months	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.	Imitates speech sounds. Correctly uses mama/dada. Understands simple command ("give it to me"). Beginning sense of humor.

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Physical and Cognitive Developmental Milestones		
Age Level	**Physical Skills**	**Cognitive Skills**
1 to 2 Years		
12 to 15 months	Stands well alone, walks well, stoops, and recovers. Neat pincer grasp. Can put a ball in a box and a raisin in a bottle. Can build a tower of two cubes. Spontaneous scribbling with palmer grasp of crayon. Fifty percent use spoon with minimal spilling. Most drink from cup unassisted.	Three- to five-word vocabulary. Uses gestures to communicate. Vocalizing replaces crying for attention. Understands "no." Shakes head for no. Sense of "me" and "mine." Fifty percent imitate household tasks.
15 to 18 months	Runs stiffly. Walks backwards. Attempts to kick. Climbs on furniture. Crude page turning. Most use spoon well. Fifty percent can help in little household tasks. Most can take off pieces of clothing.	Vocabulary of about 10 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.
18 to 24 months	While holding on, walks up stairs, then walks down stairs. Turns single pages. Builds tower of four to six cubes. Most copy vertical line. Strings beads or places rings on spindles. Helps dress and undress self. Can wash and dry hands. Most can do simple household tasks.	Markedly increased vocabulary (mostly nouns). Consistently points to body parts. Combines two to three words. Names pictures of common objects. Follows simple directions. Matches colors frequently, but uses color names randomly. Uses number words randomly. May indicate wet or soiled diapers. Asks for food or drink. Understands and asks for "another." Mimics real-life situations during play. Self-centered, but distinguishes between self and others. Conscious of family group.
2 Years	Jumps in place with both feet. Most throw ball overhead. Can put on clothing; most can dress self with supervision. Can use zippers, buckles, and buttons. Most are toilet trained. Good steering on push toys. Can carry a breakable object. Can pour from one container to another. By 30 months, alternates feet on stair climbing, pedals tricycle, briefly stands on one foot; builds eight-cube tower, proper pencil grasp, imitates horizontal line.	Learns to avoid simple hazards (stairs, stoves, etc.). By 30 months, vocabulary reaches 300 words. Identity in terms of names, gender, and place in family are well established. Uses "I," but often refers to self by first name. Phrases and 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?"

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Physical and Cognitive Developmental Milestones		
Age Level	**Physical Skills**	**Cognitive Skills**
3 Years	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.	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.
4 to 5 Years	Most hop on one foot, skip alternating feet, balance on one foot for 10 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.	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 10 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.
6 to 11 Years	Practices, refines, and masters complex gross and fine motor and perceptual skills.	Concrete operational thinking replaces egocentric cognition. Thinking becomes more logical and rational. Develops ability to understand others' perspectives.
12 to 17 Years	Physiological changes at puberty promote rapid growth, maturity of sexual organs, and development of secondary sex characteristics.	In early adolescence, precursors to formal operational thinking appear, including limited ability to think hypothetically and to take multiple perspectives.
		During middle and late adolescence, formal operational thinking becomes well developed and integrated in a significant percentage of adolescents.

Note: Adapted from *Developmental Milestones Summary*, Institute for Human Services, Columbus, OH (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.

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CALIFORNIA
CONTACT FREQUENCY GUIDELINES

ONGOING WORKER MINIMUM CONTACT FREQUENCY GUIDELINES FOR IN-HOME SERVICES		
Risk Level	**Caregiver and Child Contacts**	**Location**
Low	**One** face-to-face per month with caregiver and child **One** collateral contact	**Must** be in caregiver's residence
Moderate	**Two** face-to-face per month with caregiver and child **Two** collateral contacts	**One** must be in caregiver's residence
High	**Three** face-to-face per month with caregiver and child **Three** collateral contacts	**One** must be in caregiver's residence
Very High	**Four** face-to-face per month with caregiver and child **Four** collateral contacts	**Two** must be in caregiver's residence
Additional Considerations		
Contact Definition	Each required contact shall include at least one caregiver and one child. During the course of a month, each caregiver and each child in the household shall be contacted at least once.	
Designated Contacts	The ongoing worker/supervisor/service team may delegate face-to-face contacts to providers with a contractual relationship to the agency and/or other agency staff such as social work aids. However, the ongoing worker must always maintain at least one face-to-face contact with the caregiver and child per month, as well as monthly contact with the service provider designated to replace the ongoing worker's face-to-face contacts.	

Contact Content

1. Assess for any change in safety (vulnerability, safety threats, protective capacity, interventions).

2. Progress toward case plan objectives:
   - Participation in services
   - Demonstration of skills

3. Change in needs (identification of new needs/needs reduction).

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CONTACT FREQUENCY GUIDELINES FOR FAMILY REUNIFICATION CASES	
Risk Level	**Documented Contacts With Caregiver**
Low	One face-to-face per month with caregiver One collateral contact
Moderate	Two face-to-face per month with caregiver Two collateral contacts
High	Three face-to-face per month with caregiver Three collateral contacts
Very High	Three face-to-face per month with caregiver Three collateral contacts
	Documented Contacts With Children
	At least one face-to-face per month with each child
Additional Considerations	
Contact Definition	During the course of a month, each caregiver and each child shall be contacted at least once.
Designated Contacts	The ongoing worker must always maintain at least one face-to-face contact per month with the caregiver. However, the ongoing worker may delegate remaining contacts to service providers outlined in the case plan or other agency staff.
Overrides	A discretionary override to these contact frequency guidelines is permitted based on unique case circumstances that are documented by the ongoing worker and approved by the supervisor. All case contacts must at least meet Division 31 regulations.

Contact Content

1. Assess for any change in safety (vulnerability, safety threats, protective capacity, interventions).

2. Progress toward case plan objectives:
   - Participation in services
   - Demonstration of skills

3. Change in needs (identification of new needs/needs reduction).

4. Visitation quality.

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CALIFORNIA
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES

r: 06/15

Case Name: _____ **Case #:** _____ **Date:** _____/_____/_____

County Name: _____ **Worker Name:** _____ **Worker ID#:** _____

The first four items are scored based on conditions that were present at the time of the referral that resulted in the case opening. Unless new information has been learned about those conditions, these should be scored the same as on the initial risk assessment.

R1. Number of prior neglect or abuse CPS investigations — **Score**

a. None 0
b. One or two 1
c. Three or more ..... 2 _____

R2. Household has previously had an open CPS case (voluntary/court ordered)

a. No 0
b. Yes ..... 1 _____

R3. Primary caregiver has a history of abuse and/or neglect as a child

a. No 0
b. Yes ..... 1 _____

R4. Characteristics of children in the household

a. Not applicable 0
b. One or more present (*mark all applicable for any child*) ..... 1 _____
☐ Developmental disability
☐ Learning disability
☐ Physical disability
☐ Medically fragile or failure to thrive

The following case observations pertain to the period since the last assessment/reassessment.

R5. New investigation of abuse or neglect since the initial risk assessment or the last reassessment

a. No 0
b. Yes ..... 2 _____

R6. Primary/secondary caregiver alcohol and/or drug use since the last assessment/reassessment (*mark one*)

P S
☐ ☐ a. No history of alcohol or drug abuse 0
☐ ☐ b. No current alcohol or drug abuse; no intervention needed 0
☐ ☐ c. Yes, alcohol or drug abuse; problem is being addressed 0
☐ ☐ d. Yes, alcohol or drug abuse; problem is <u>not</u> being addressed ..... 1 _____

R7. Adult relationships in the home

a. None applicable 0
b. Yes (*mark all that apply*) ..... 1 _____
☐ Harmful/tumultuous relationships
☐ Domestic violence

R8. Primary caregiver mental health since the last assessment/reassessment (*mark one*)

a. ☐ No history of mental health problem 0
b. ☐ No current mental health problem; no intervention needed 0
c. ☐ Yes, mental health problem; problem is being addressed 0
d. ☐ Yes, mental health problem; problem is <u>not</u> being addressed ..... 1 _____

R9. Primary caregiver provides physical care of the child that is:

a. Consistent with child needs 0
b. Not consistent with child needs ..... 1 _____

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R10. Caregiver's progress with case plan objectives (as indicated by behavioral change) **Score**

(score based on the caregiver demonstrating the least progress)

P S

☐ ☐ a. Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged to maintain objectives 0

☐ ☐ b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives 0

☐ ☐ c. Minimally demonstrates new skills and behaviors consistent with case plan objectives and/or has been inconsistently engaged in obtaining the objectives specified in the case plan 0

☐ ☐ d. Does not demonstrate new skills and behaviors consistent with case plan objectives and/or refuses engagement ..... 1 _____

☐ No secondary caregiver

TOTAL SCORE _____

SCORED RISK LEVEL. Assign the family's risk level based on the following chart.

Score	Risk Level
0–1	☐ Low
2–4	☐ Moderate
5–7	☐ High
8+	☐ Very High

OVERRIDES

Policy Overrides. Mark yes if condition is applicable in the current review period. If any condition is applicable, override final risk level to very high.

☐ Yes ☐ No 1. Sexual abuse case AND the perpetrator is likely to have access to the child.

☐ Yes ☐ No 2. Non-accidental injury to a child under age 2.

☐ Yes ☐ No 3. Severe non-accidental injury.

☐ Yes ☐ No 4. Caregiver action or inaction resulted in death of a child due to abuse or neglect.

Discretionary Override. If a discretionary override is made, mark yes, mark override risk level, and indicate the 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

Final Risk Level	Recommendation
Low	Close*
Moderate	Close*
High	Continue Services
Very High	Continue Services

*Unless there are unresolved safety threats.

PLANNED ACTION

☐ Continue Services

☐ Close **Note: A closing safety assessment is required.**

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

_____

_____

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CALIFORNIA
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES
DEFINITIONS

R1. Number of prior neglect or abuse CPS investigations

Identify the number of assigned physical abuse, sexual abuse, emotional abuse, and/or neglect investigations prior to the investigation resulting in the current case, regardless of whether the allegations were substantiated, inconclusive, or unfounded.

Do not include referrals that were not assigned for investigation or investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

a. Choose "a" if there were no prior assigned investigations.
b. Choose "b" if there were one or two prior assigned investigations.
c. Choose "c" if there were three or more prior assigned investigations.

R2. Household has previously had an open CPS case (voluntary/court-ordered)

Identify whether the household has had an open CPS case prior to the investigation resulting in the current case. This applies to the household that has been investigated and opened in the current case.

Service history includes voluntary or court-ordered family services, but not delinquency services.

a. Choose "a" if the household has not had a prior open CPS case.
b. Choose "b" if the household has one or more prior open CPS cases.

R3. Primary caregiver has a history of abuse and/or neglect as a child

Identify whether the primary caregiver was a victim of child abuse/neglect as a child. Are there credible statements by the primary caregiver or others and/or documentation that indicate the primary caregiver was maltreated as a child? (Maltreatment includes neglect or physical, sexual, or emotional abuse.)

a. Choose "a" if the primary caregiver was not maltreated as a child.
b. Choose "b" if the primary caregiver was maltreated as a child.

R4. Characteristics of children in the household

Identify whether any child in the household has a developmental, learning, and/or physical disability, or is diagnosed as medically fragile or failure to thrive. Base identification on credible information from a caregiver that a child has been diagnosed, statements from a physician or mental health professional, or review of records.

a. Choose "a" if no child in the household exhibits characteristics listed below.

b. Choose "b" if any child in the household exhibits characteristics listed below and mark all types present.

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- Developmental disability. A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

- Learning disability. Child has an individualized education plan (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 or failure to thrive.

  » "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 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 an ongoing threat to his/her continued well-being. Examples include a child who requires a trach-vent for breathing or a g-tube for eating.

  » 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 of abuse or neglect since the initial risk assessment or the last reassessment

Identify whether there was at least one investigation initiated since the initial risk assessment or last reassessment. This includes open or completed investigations, regardless of the investigation's conclusion, that have been initiated since the initial assessment or last reassessment. Do not include duplicate referrals.

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R6. Primary/secondary caregiver alcohol and/or drug use since the last assessment/reassessment

Identify alcohol/drug use by the caregiver(s) during the review period, whether there is a current problem that interferes with caregiver functioning or family functioning, and if so, how the caregiver(s) has addressed the problem during the review period.

Non-abusive use of legal prescription drugs or over-the-counter medications should not be identified as an issue.

If both caregivers have a substance abuse problem, rate the more negative behavior of the two caregivers.

Not addressing the problem since the last assessment/reassessment includes:

- Substance use that affects or affected employment, criminal involvement, or marital or family relationships; and/or that affects or affected caregiver's 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;
- Treatment received currently or in the past;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use and/or abuse; or
- The child's diagnosis with fetal alcohol syndrome or exposure, or the child's positive toxicology screen at birth and the primary caregiver was the birth parent.

a. Choose "a" if there is no history of alcohol or drug abuse.

b. Choose "b" if there is a history of alcohol or drug abuse that is not current and did not require intervention during the review period.

c. Choose "c" if there is alcohol or drug abuse, and the problem is being addressed.

d. Choose "d" if there is alcohol or drug abuse, and the problem is <u>not</u> being addressed.

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R7. Adult relationships in the home

Identify the current status of adult relationships in the household.

a. Choose "a" if not applicable or there are no problems observed.

b. Choose "b" if there are harmful/tumultuous adult relationships or domestic violence.

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

- 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 mental health since the last assessment/reassessment

Determine the primary caregiver's current mental health status. Does the caregiver have a current diagnosis of a significant mental health problem that impacts daily functioning, as determined by a mental health clinician, and if so, is the problem being addressed?

Not addressing the problem includes a caregiver who during the review period:

- Has a mental health condition that affects or affected the caregiver's employment, criminal involvement, or marital or family relationships; or that affects or affected his/her ability to provide protection, supervision, and care for the child;

- Has had referrals for mental health/psychological evaluations; or

- Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

a. Choose "a" if the primary caregiver does not have a current or past mental health problem.

b. Choose "b" if there is a history of mental health problems, but within the last year, there is no mental health problem that requires intervention.

c. Choose "c" if there is a mental health problem, and the problem is being addressed.

d. Choose "d" if there is a mental health problem, and the problem is not being addressed.

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R9. Primary caregiver provides physical care of the child that is:

Determine whether the child's physical care is consistent with the child's needs (age-appropriate feeding, clothing, shelter, hygiene, and medical care). Physical care that is not consistent with the child's needs threatens the child's well-being or results in harm to the child. Examples of physical care that is not consistent with child need include but are not limited to:

- Repeated failure to obtain physician-recommended immunizations;
- Failure to obtain medical care for severe or chronic illness;
- Repeated failure to provide the child with weather-appropriate clothing;
- Persistent rat or roach infestations;
- Inadequate or inoperative plumbing or heating;
- Poisonous substances or dangerous objects lying within reach of small child;
- The child wears filthy clothes for extended periods of time; or
- The child is not being bathed on a regular basis, resulting in dirt caked on skin and hair and a strong odor.

a. Choose "a" if physical care is consistent with child needs.
b. Choose "b" if physical care is not consistent with child needs.

R10. Caregiver's progress with case plan objectives (as indicated by behavioral change)

Compliance with/attendance of services is not sufficient to indicate behavioral change. Identify whether a caregiver is actively engaged in achieving the case plan objectives specified in the case plan and is demonstrating skills/behaviors that will enable the caregiver to create, and maintain, safety for the child (e.g., ability to manage substance use/abuse; ability to resolve conflict constructively and respectfully; using age-appropriate, non-physical discipline in conjunction with appropriate boundary setting; developing a mutually supportive relationship with a partner).

"Case plan objectives" specifically refers to the service objective type in the CWS/CMS case plan, identifying the changes in caregiver behavior necessary to create and maintain safety.

If there are two caregivers, rate progress for each. If progress differs between caregivers, score the item based on the caregiver who is demonstrating the least amount of participation/progress.

a. <u>Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged to maintain objectives</u>. Choose "a" if the caregiver is regularly demonstrating all behavioral changes identified in the case plan objectives and is able to create long-term safety for children in the household. The caregiver is actively engaged in activities to maintain the objectives.

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b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives. Choose "b" if the caregiver is demonstrating some new skills and behavioral change consistent with case plan objectives and is actively engaged in achieving the objectives, but is not regularly demonstrating the behaviors necessary to create long-term safety in all areas.

c. Minimally demonstrates new skills and behaviors consistent with case plan objectives and/or has been inconsistently engaged in obtaining the objectives specified in the case plan. Choose "c" if the caregiver is demonstrating minor behavioral change consistent with family case plan outcomes but has made little progress toward changing his/her behavior and is not actively engaged in achieving the objectives. Caregiver behavior continues to make it difficult to create safety or may contribute to immediate danger of serious harm.

d. Does not demonstrate new skills and behaviors consistent with case plan objectives and/or refuses engagement. Choose "d" if the caregiver has not demonstrated behavioral change consistent with family service plan objectives. The caregiver refuses services, sporadically follows the case plan, or has not demonstrated the necessary skills/behaviors due to a failure or inability to participate. The caregiver is unable to create or maintain safety or his/her behavior is likely to contribute to immediate danger of serious harm.

OVERRIDES

After determining the scored risk level, assess whether any override conditions are present. Consider only the most recent review period. If this is the first risk reassessment, consider the period since the initial risk assessment. If this is not the initial risk reassessment, consider the period since the last risk reassessment. Discretionary overrides require supervisory approval.

Policy Overrides

Indicate whether a policy override condition exists. Consider only the most recent review period. Presence of one or more mandatory override conditions increases the risk level to very high.

1. Sexual abuse case AND the perpetrator is likely to have access to the child. One or more of the children in this household are or have been victims of sexual abuse AND the perpetrator is likely to have unmanaged access.

2. Non-accidental injury to a child under age 2. Any child under 2 years old in the household has any kind of physical injury resulting from the actions or inactions of a caregiver.

3. Severe non-accidental injury. Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, or severe cuts, AND the child requires medical treatment.

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4. Caregiver action or inaction resulted in death of a child due to abuse or neglect. Any child in the household has died as a result of actions or inactions by the caregiver. This child fatality may have occurred prior to the current case.

Discretionary Override

A discretionary override is used by the ongoing worker whenever the worker believes that 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 risk 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 six months, the worker has acquired significant knowledge of the household. If the worker applies a discretionary override, the reason should be specified and the final risk level should be marked.

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CALIFORNIA
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES
POLICY AND PROCEDURES

The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently to allow a case to be closed, or whether the risk level remains high and services should continue. This is accomplished through evaluating whether **behaviors and actions** of the family has changed as a result of the case plan.

The family risk reassessment combines items from the original risk assessment with additional items that evaluate a family's progress toward case 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 cases in which all children remain in the home, or cases in which all children have been returned home and family maintenance services will be provided.

Who: The case-carrying worker.

When: *Prior to each Division 31 required review, which occurs at least once every six months, and any recommendation to close the case or continue services. To ensure that current SDM assessments are available, they should be completed:*

Voluntary Cases
- No more than 30 calendar days prior to completing each case plan.
- No more than 30 calendar days prior to recommending case closure.

Involuntary Cases
- No more than 65 calendar days prior to completing each case plan.
- No more than 65 calendar days prior to recommending case closure.

All Cases
Should 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 close a case.

Risk-Based Case Open/Close Guide	
Risk Level	**Recommendation**
Low	Close, if there are no unresolved safety threats
Moderate	Close, if there are no unresolved safety threats
High	Case remains open
Very High	Case remains open

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For cases that remain open following reassessment, the NEW risk level guides minimum contact standards that will be in effect until the next reassessment is completed. Use the contact frequency guidelines in Section VI of this manual.

Appropriate Completion

Scoring Individual Items

Workers should familiarize themselves with the items that are included on the risk reassessment and the accompanying definitions for those items. A score for each item is derived from the worker's observation of the characteristics it describes during interviews with household members (child, caregivers, and others) and collaterals; worker observations; reports and case records; or other reliable sources concerning progress in demonstrating behavioral change and meeting case plan objectives. Some characteristics are objective, such as prior child abuse/neglect history or the age of the child. Others require the worker to use discretionary judgment based on his/her assessment of the family.

Using the definitions for the risk reassessment, complete all items on the risk reassessment and consider whether any override reasons are present.

Risk items R1–R4: The first four items on the risk reassessment generally are scored the same way as the first four items on the initial risk assessment, unless new information has become available about conditions that existed at the time of the initial risk assessment. Review the initial risk assessment to determine the scores and consider all information currently available.

Risk items R5–R10. These items are scored based ONLY on observations since the most recent assessment or reassessment.

When all items are scored, total the scores to determine the scored risk level following the instructions on the form.

Override

Consider both policy and discretionary overrides. If any are present, then determine the final risk level. If no overrides are present, then the scored and final risk level are the same.

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 have occurred since the initial risk assessment or the last reassessment. If one or more policy override conditions exist, mark "yes" for each reason for the override and mark "very high" for the final risk level. Policy overrides require supervisory review.

Discretionary Override

A discretionary override is used by the ongoing 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 a minimum of six months, the worker has acquired significant knowledge of the family. If a

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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.

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

Examples of explanations include the following:

- Continuing a low or moderate case:
  - » Unresolved safety threats. Based on the SDM safety assessment, one or more safety threats could not be resolved.
- Closing a high-risk or very high-risk case:
  - » Family declined voluntary family maintenance services AND no petition. Family was informed of their high or very high risk level and was encouraged to continue voluntary family maintenance services. The family declined AND no petition will be filed. Mark this item even if family does accept any non-CPS services.
  - » Family is receiving or has been connected with community services that will address priority needs and/or contributing factors. The family is already engaged in services OR the worker will assist the family in making connections to community services (worker must be certain that an appointment was made and verify follow-through). These services are directly related to the priority needs identified using the family strengths and needs assessment or other means to identify factors that contribute to risk.

Practice Considerations
Case workers should explain to the family, at the start of the service period, the structure and process for conducting the reassessment, and should link the reassessment process to the developed case plan.

Case workers should use formal and informal family engagement strategies during monthly in-person contacts or periodically scheduled family meetings to gather information about change over time, which should be documented in the case record. This aggregate information can then form the basis for scoring the formal reassessment.

Use of formal engagement strategies, such as family team meetings to conduct the formal reassessment and develop an updated case plan or engage in planning for case closure, is highly recommended.

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CALIFORNIA
SDM® REUNIFICATION REASSESSMENT

Case Name: _____ **Date Completed:** _____/_____/_____

Case #: _____ **Household Assessed:** _____

Is this the removal household? ☐ Yes ☐ No **Assessment # (mark):** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

To be completed for each household to which a child may be returned (e.g., father's home, mother's home).

A. REUNIFICATION RISK REASSESSMENT

R1. Risk level on most recent referral (not reunification risk level or risk reassessment) — **Score**

a. Low 0
b. Moderate 3
c. High 4
d. Very high ..... 5 _____

R2. Has there been a new substantiation since the initial risk assessment or last reunification reassessment?

a. No 0
b. Yes ..... 2 _____

R3. Caregiver's progress with case plan objectives (as indicated by behavioral change)
(Compliance with/attendance of services is not sufficient to indicate behavioral change.)

P	S		
☐	☐	a. Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged to maintain objectives	−2
☐	☐	b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives	−1
☐	☐	c. Minimally demonstrates new skills and behaviors consistent with case plan objectives and/or has been inconsistently engaged in obtaining the objectives specified in the case plan	0
☐	☐	d. Does not demonstrate new skills and behaviors consistent with case plan objectives and/or refuses engagement	4 _____
	☐	No secondary caregiver	

Total Score _____

REUNIFICATION RISK LEVEL

Assign the risk level based on the following chart.

Score	Risk Level
−2 to 1	☐ Low
2–3	☐ Moderate
4–5	☐ High
6+	☐ Very High

OVERRIDES

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

☐ 1. Sexual abuse; perpetrator has access to child and has not successfully completed treatment.
☐ 2. Non-accidental physical injury to an infant, and caregiver has not successfully completed treatment.
☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment, and caregiver has not successfully completed treatment.
☐ 4. Death of a sibling as a result of abuse or neglect in the household, and caregiver has not successfully completed treatment.

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: _____/_____/_____

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B. VISITATION PLAN EVALUATION

Evaluate compliance with the planned visitation frequency and the quality of visits, based on the worker's direct observation whenever possible and supplemented by observation of the child, reports by foster parents, etc.

Visitation Frequency **Compliance With Visitation Plan**	**Quality of Face-to-Face Visit**	
	Strong/ Adequate	**Limited/ Destructive**
Total		
Routine		
Sporadic		
Rare or Never		

Shaded cells indicate acceptable visitation.

Overrides

☐ Policy: Visitation is supervised for safety.
☐ Discretionary (reason): _____

IF RISK LEVEL IS LOW OR MODERATE AND CAREGIVER HAS ATTAINED AN ACCEPTABLE LEVEL OF COMPLIANCE WITH VISITATION PLAN, CONTINUE TO SECTION C, REUNIFICATION SAFETY ASSESSMENT.

IF RISK LEVEL IS HIGH OR VERY HIGH AND/OR VISITATION IS UNACCEPTABLE, GO TO SECTION D, PLACEMENT/PERMANENCY PLAN GUIDELINES. DO NOT COMPLETE SECTION C.

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C. REUNIFICATION SAFETY ASSESSMENT

Safety Threats

1. Are any safety threats identified on the safety assessment that resulted in the child's removal still present?

☐ a. No; list the initial safety threats and describe below how the initial safety threat(s) was ameliorated or mitigated after the child's removal.
☐ b. Yes; list and describe safety threat(s) as it currently exists below.

Describe: _____
_____

1a. If yes, is there a safety intervention that can and will be incorporated into the case plan to mitigate these safety threats?
☐ No; there are no safety interventions available and appropriate to mitigate safety concerns if the child were to be reunified at this time.
☐ Yes; one or more safety interventions have been identified to mitigate safety concerns and allow reunification to proceed with an in-home safety plan in place.

Describe: _____
_____

2. Have any new safety threats been identified since the child's removal or are there any other circumstances or conditions present in the reunification household that, if the child were returned home, would present an immediate danger of serious harm?
☐ a. No
☐ b. Yes

Describe: _____
_____

2a. If yes, is there a safety intervention(s) that can and will be incorporated into the case plan to mitigate these safety threats?
☐ No; there are no safety interventions available and appropriate to mitigate safety concerns if the child were reunified at this time.
☐ Yes; one or more safety interventions have been identified to mitigate safety concerns and allow reunification to proceed with an in-home safety plan in place.

Describe: _____
_____

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 plan. One or more safety threats are present, and protective safety interventions have been planned or taken. Based on safety interventions, the child would be safe with a safety plan in place upon his/her return home. SAFETY PLAN REQUIRED.

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

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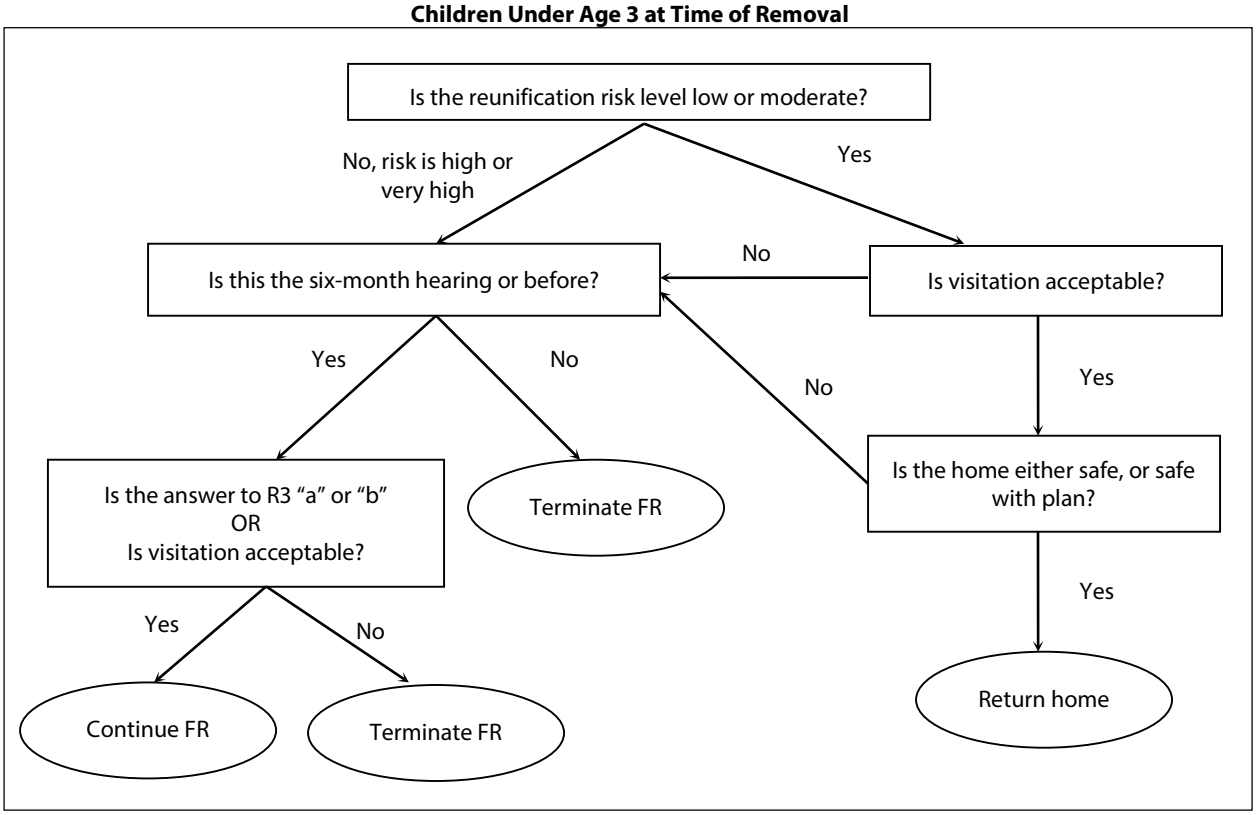
D. PLACEMENT/PERMANENCY PLAN GUIDELINES

Complete one of the following trees for each child receiving family reunification services (FR), depending on whether he/she is over or under age 3, and enter the results in Section E. Consult with supervisor and appropriate statutes and regulations.

Children Under Age 3 at Time of Removal



OVERRIDES (select one)

☐ No override applicable (policy or discretionary).

Policy Override

☐ Child has been in placement for 15 of the last 22 months (change recommendation to "Terminate FR").

☐ The tree leads to "Terminate FR" and it is the six-month hearing or before, BUT there is a probability of reunification within six months (change recommendation to "Continue FR").

☐ The tree leads to "Continue FR," but conditions exist to recommend termination of FR (change recommendation to "Terminate FR").

Specify: _____

_____

Discretionary Override

☐ Change recommendation to:

☐ Return Home ☐ Continue FR ☐ Terminate FR

Specify: _____

_____

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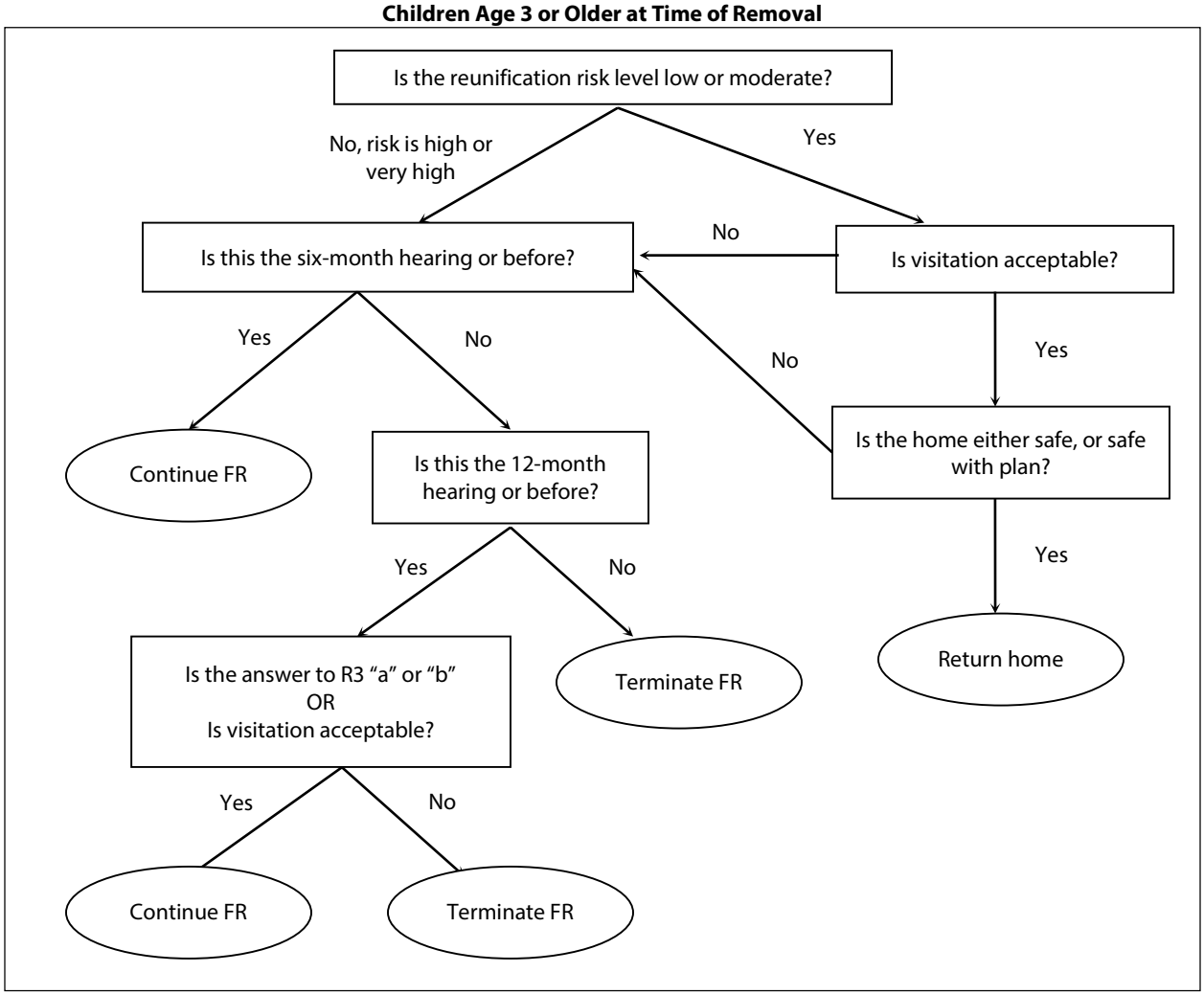
Children Age 3 or Older at Time of Removal



OVERRIDES (select one)

☐ No override applicable (policy or discretionary).

Policy Override

☐ Child has been in placement for 15 of the last 22 months (change recommendation to "Terminate FR").

☐ The tree leads to "Terminate FR" and it is the 12-month hearing or before, BUT there is a probability of reunification within six months (change recommendation to "Continue FR").

☐ The tree leads to "Continue FR," but conditions exist to recommend termination of FR (change recommendation to "Terminate FR").

Specify: _____

_____

Discretionary Override

☐ Change recommendation to:

☐ Return Home ☐ Continue FR ☐ Terminate FR

Specify: _____

_____

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

Child #	Recommendation		
	Return Home	Continue Family Reunification Services	Terminate Family Reunification Services; Implement Permanent Alternative
1.			
2.			
3.			
4.			

F. SIBLING GROUP
If at least one child under the age of 3 at the time of removal has a recommendation of "terminate family reunification services" and at least one other child has any other recommendation, will all children be considered a sibling group when making the final permanency plan recommendation?

☐ No
☐ Yes. The recommendation for all children will be "terminate family reunification services."

If the decision is to return any children home, complete a safety assessment to document the plan for any children for whom safety threats were identified.

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CALIFORNIA
SDM® REUNIFICATION REASSESSMENT
DEFINITIONS

A. REUNIFICATION RISK REASSESSMENT

R1. Risk level on most recent referral (not reunification risk level or risk reassessment)
Identify and record the final risk level from the risk assessment completed for the most recent investigation. This is either the investigation that led to case opening or placement, or the most recent subsequent assigned referral that was investigated. If an initial risk assessment was not completed on the referral that led to case opening or a subsequent assigned referral, score "c" (high risk) as the initial risk level for the household.

Do not use a prior risk reassessment or reunification reassessment risk level.

R2. Has there been a new substantiated investigation since the initial risk assessment or the last reunification reassessment?
Identify whether there has been a new substantiated investigation since either the initial risk assessment that led to case opening or, if at least one reunification reassessment has been completed, the most recent reunification reassessment.

a. Choose "a" if there has not been a substantiated investigation in the review period.
b. Choose "b" if there has been at least one substantiated investigation.

R3. Caregiver's progress with case plan objectives (as indicated by behavioral change) (Compliance with/attendance of services is not sufficient to indicate behavioral change.)
Identify whether a caregiver is actively engaged in achieving the case plan objectives specified in the case plan and is demonstrating the skills/behaviors (e.g., ability to manage substance use/abuse; ability to resolve conflict constructively and respectfully; using age-appropriate, nonphysical discipline in conjunction with appropriate boundary setting; developing a mutually supportive relationship with partner) that will enable the caregiver to create and maintain safety for the child.

"Case plan objectives" specifically refers to the service objective type in the child welfare services case management system (CWS/CMS) case plan, identifying the changes in caregiver behavior that are necessary to create and maintain safety.

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. <u>Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged to maintain objectives</u>. Choose "a" if the caregiver is regularly demonstrating all behavioral changes identified in the case plan objectives and is able to create long-term safety for children in the household. The caregiver is actively engaged in activities to maintain the objectives.

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b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives. Choose "b" if the caregiver is demonstrating some new skills and behavioral changes consistent with case plan objectives and is actively engaged in achieving the objectives, but is not regularly demonstrating the behaviors necessary to create long-term safety in all areas.

c. Minimally demonstrates new skills and behaviors consistent with case plan objectives and/or has been inconsistently engaged in obtaining the objectives specified in the case plan. Choose "c" if the caregiver is demonstrating minor behavioral change consistent with family case plan outcomes but has made little progress toward changing his/her behavior and is not actively engaged in achieving the objectives. Caregiver behavior continues to make it difficult to create safety or may contribute to immediate danger of serious harm.

d. Does not demonstrate new skills and behaviors consistent with case plan objectives and/or refuses engagement. Choose "d" if the caregiver has not demonstrated behavioral change consistent with family service plan objectives. The caregiver refuses services, sporadically follows the case plan, or has not demonstrated the necessary skills/behaviors due to a failure or inability to participate. The caregiver is unable to create or maintain safety, and his/her behavior is likely to contribute to immediate danger of serious harm.

Overrides

After determining the scored risk level, assess whether any override conditions are present. Consider only the most recent review period. If this is the first reunification reassessment, consider the period since the initial risk assessment. If this is *not* the initial reunification reassessment, consider the period since the last reunification reassessment. Overrides require supervisory approval.

Policy Overrides

Indicate whether a policy override condition exists. The presence of one or more mandatory policy override conditions increases the risk level to very high.

1. Sexual abuse; perpetrator has access to child and has not successfully completed treatment. One or more of the children in this household is or has been a victim of sexual abuse. The perpetrator is likely to have unmanaged access to the victim and the perpetrator has not completed treatment.

2. Non-accidental injury to an infant, and caregiver has not successfully completed treatment. An infant in the household has a physical injury resulting from the actions or inactions of a caregiver, and the caregiver has been referred to treatment but has not yet completed the treatment.

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3. Serious non-accidental physical injury requiring hospital or medical treatment, and caregiver has not successfully completed treatment. Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, or severe cuts, AND the child requires medical treatment. The caregiver has been referred for treatment but has not yet completed the treatment.

4. Death of a sibling as a result of abuse or neglect in the household, and caregiver has not successfully completed treatment. Any child in the household has died as a result of actions or inactions by the caregiver. This child fatality may have occurred prior to the current case. The caregiver has been referred for treatment but has not yet completed the treatment.

Discretionary Override

A discretionary override is used by the ongoing worker whenever the worker believes that 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 six months, the worker has acquired significant knowledge of the household. If the worker applies a discretionary override, the reason should be specified and the final reunification risk level should be marked.

B. VISITATION PLAN EVALUATION

Visitation Frequency—Compliance With Visitation Plan

Divide the total number of completed visits by the number of planned visits. Visits that are appreciably shortened by late arrival/early departure are considered missed. Do not count visits as missed or planned that did not occur for reasons not attributable to the household (e.g., foster parent failed to make the child available, transportation that the agency was required to provide did not occur).

$$\frac{\text{Actual visits}}{\text{Available visits}} = \text{Visitation frequency}$$

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

Routine: Caregiver misses visits occasionally and rarely requests to reschedule visits (65% to 89% compliance).

Sporadic: Caregiver misses or reschedules many scheduled visits (26% to 64% compliance).

Rare or Never: Caregiver does not visit or attends 25% or fewer of the allowed visits (0% to 25% compliance).

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Quality of Face-to-Face Visit

Quality of visit is based on the worker's direct observation whenever possible, supplemented by observation of child, reports of foster parents, etc.

Quality of Face-to-Face Visit	
Strong/Adequate	**Caregiver** • Consistently demonstrates acts of protection and supportive behaviors toward the child that are consistent with case plan objectives. • Often reinforces appropriate roles and boundaries for child (e.g., caregiver preserves parent-child relationship or takes on adult roles and responsibilities). • Demonstrates an ability to recognize child's behaviors and cues; generally responds appropriately to behaviors and cues. • Identifies the child's physical and emotional needs; responds adequately to these needs. • Demonstrates effective limit-setting and discipline strategies. • Demonstrates a focus on the child during visits; shows empathy to child. • Demonstrates interest in school, other child activities, medical appointments, etc. Note: Visitation may have progressed to include unsupervised and/or extended visits, but progression to extended visits is not required in order to score the quality of visits as adequate/strong.
Limited/ Destructive	**Caregiver** • May not demonstrate acts of protection and supportive behaviors toward the child that are consistent with case plan objectives. • 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. • 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 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. • 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 have ignored redirection by supervising worker.

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Quality of Face-to-Face Visit	
	• May not be focused on child during parenting time and/or conducts self inappropriately during visit (e.g., arriving for parenting time while substance-impaired, reinforcing "parentification" of child, knowingly making false promises to child, cursing at/violently arguing with worker in presence of child). • Has not been successful in progressing visitation toward unsupervised and/or extended visits, or has had significant visitation setbacks that have required increasing supervision due to safety concerns for the child.

Overrides

Policy

Visitation is supervised for safety. The agency has determined that reunification will not be considered if there is a requirement that all visits be supervised for the child's safety.

Discretionary
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 visits was strong, and 64% of visits were completed; all missed visits were due to documented medical emergencies).

C. REUNIFICATION SAFETY ASSESSMENT

Safety Threats[1]
Prior to assessing current safety, the worker should review the safety assessment that led to removal.

1. **Are any safety threats identified on the safety assessment that resulted in the child's removal still present?**
   Identify whether the safety threats that resulted in the child's removal have been resolved. Review the original safety assessment, list the initial safety threats, and describe how the initial safety threats were resolved OR, if not resolved, what the current circumstances are that would pose an immediate threat of harm if the child were to be reunified.

   Consider how safe the child would be if he/she were to be returned home at this time. Consider current conditions in the home, current caregiver characteristics, child characteristics, and interactions between the caregiver and child during visitation.

[1] The SDM Safety Assessment Definitions section is reproduced on pages 156–167 to assist workers in thinking about safety threats while considering these questions.

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1a. If yes, is there a safety intervention that can and will be incorporated into the case plan to mitigate these safety threats?
Identify whether any safety interventions are available and appropriate to mitigate any identified safety threats. Use the definitions provided in webSDM to review both safety threats and safety interventions.

2. Have any new safety threats been identified since the child's removal or are there any other circumstances or conditions present in the reunification household that, if the child were returned home, would present an immediate danger of serious harm?
Identify whether any new safety threats have emerged during the review period. Review the safety threat definitions provided in webSDM. If any new safety threats are identified that would pose an immediate threat of serious harm to a child if he/she were reunified, describe the conditions and circumstances.

2a. If yes, is there a safety intervention(s) that can and will be incorporated into the case plan to mitigate these safety threats?
Identify whether any safety interventions are available and appropriate to mitigate any newly identified safety threats. Use the safety threat and safety intervention definitions provided in webSDM to determine whether there are any new safety threats.

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 plan. One or more safety threats are present, and protective safety interventions have been planned or taken. Based on safety interventions, the child would be safe with an in-home safety plan upon his/her return home. SAFETY PLAN REQUIRED.

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

D. PLACEMENT/PERMANENCY PLAN GUIDELINES

Overrides
Consider whether any overrides are applicable. If no overrides apply, mark "No overrides 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.

Policy

For all children

- Child has been in placement for 15 of the last 22 months: Change to "Terminate FR."

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- The tree leads to "Continue FR," but conditions exist to recommend termination of FR (change to "Terminate FR"). Conditions exist to recommend termination.
    - » The child was removed under WIC § 300 (g) (abandonment) and whereabouts of the caregiver are still unknown.
    - » The caregiver has failed to contact and visit the child.
    - » The caregiver has been convicted of a felony indicating parental unfitness based on WIC § 366.21 (e).

For children under age 3 at time of most recent removal

- The tree leads to "Terminate FR" and it is the **six-month hearing** or before, BUT there is a probability of reunification within six months (change to "Continue FR"). There is a probability of reunification within six months, based on the requirements of California Welfare and Institutions Code (WIC) § 366.21 (g) (1) (A–C).
    - » The caregiver has consistently and regularly contacted and visited the child.
    - » The caregiver has made substantial progress in resolving problems that led to the child's removal from home.
    - » The caregiver has demonstrated the capacity and ability to both complete the objectives of his/her treatment plan and provide for the child's safety, protection, physical and emotional well-being, and special needs.

For children ages 3 and over at time of most recent removal

- The tree leads to "Terminate FR" and it is the **12-month hearing** or before, BUT there is a probability of reunification within six months (change to "Continue FR"). There is a probability of reunification within six months, based on the requirements of California Welfare and Institutions Code (WIC) § 366.21 (g) (1) (A–C).
    - » The caregiver has consistently and regularly contacted and visited the child.
    - » The caregiver has made substantial progress in resolving problems that led to the child's removal from home.
    - » The caregiver has demonstrated the capacity and ability to both complete the objectives of his/her treatment plan and provide for the child's safety, protection, physical and emotional well-being, and special needs.

Discretionary

Unique considerations exist that warrant an alternative decision. If yes, indicate the permanency plan goal that is being recommended (Return Home, Continue FR, Terminate FR).

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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 Division 31 regulations and Welfare and Institution Code statutes and should consult with his/her supervisor.

For each child being assessed, record the final recommendation.

F. SIBLING GROUP

This section applies only if at least one child under the age of 3 at the time of removal was recommended for termination of reunification services, 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, the recommendation for all children will be "terminate reunification services."

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CALIFORNIA
SDM® SAFETY ASSESSMENT
DEFINITIONS

Factors Influencing Child Vulnerability (conditions resulting in child's inability to protect self; mark all that apply to any child in the household)

- Age 0–5 years. Any child in the household is under the age of 5. Younger children are considered more vulnerable, as they are less verbal and less able to protect themselves from harm. Younger children also have less capacity to retain memory of events. Infants are particularly vulnerable, as they are nonverbal and completely dependent on others for care and protection.

- Significant diagnosed medical or mental disorder. Any child in the household has a diagnosed medical or mental disorder that significantly impairs ability to protect him/herself from harm, OR diagnosis may not yet be confirmed but preliminary indications are present and testing/evaluation is in process. Examples may include but are not limited to: severe asthma, severe depression, medically fragile (e.g., requires assistive devices to sustain life), etc.

- Not readily accessible to community oversight. The child is isolated or less visible within the community (e.g., the family lives in an isolated community, the child may not attend a public or private school or be routinely involved in other activities within the community, etc.).

- Diminished developmental/cognitive capacity. Any child in the household has diminished developmental/cognitive capacity, which impacts ability to communicate verbally or to care for and protect self from harm.

- Diminished physical capacity (e.g., non-ambulatory, limited use of limbs). Any child in the household has a physical condition/disability that impacts ability to protect self from harm (e.g., cannot run away or defend self, cannot get out of the house in an emergency situation if left unattended).

SECTION 1: SAFETY THREATS

1. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by:

- Serious injury or abuse to the child other than accidental. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, or severe cuts, and the child requires medical treatment.

  Caregiver fears he/she will maltreat the child. The caregiver has reported credible fears that he/she will hurt the child in a way that would cause serious injury and/or requests placement.

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- 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 child protective services (CPS) investigation.

- Domestic violence likely to injure child. There have been incidents of household violence that created danger of serious physical injury to the child AND there is reason to believe that this may occur again (e.g., alleged domestic violence perpetrator and victim are still involved in relationship; a pattern of household violence continues to exist). For example:

  » Child was in the arms of one person during a violent episode;

  » A gun, knife, or other implement was involved;

  » Child attempted to intervene or was near enough to the violent altercation that he/she was in harm's way; or

  » Child was previously injured in a domestic/family violence incident (e.g., fractures, bruising, cuts, or burns) and there is violence occurring now.

- Excessive discipline or physical force. The caregiver used physical methods to discipline a child that resulted or could easily result in serious injury, OR caregiver injured or nearly injured a child by using physical force for reasons other than discipline.

- Drug/alcohol-exposed infant. There is evidence that the mother used alcohol or other drugs 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.

  » Indicators of imminent danger include: the level of toxicity and/or type of drug present, the infant is diagnosed as medically fragile as a result of drug exposure, or the infant suffers adverse effects from introduction of drugs during pregnancy.

2. **Child sexual abuse is suspected, AND circumstances suggest that the child's safety may be of immediate concern.**
   Suspicion of sexual abuse may be based on indicators such as:

   - The child discloses sexual abuse verbally.

   - The child displays behaviors that strongly indicate sexual abuse (e.g., excessive, age-inappropriate sexualized behavior toward self or others).

   - Medical findings consistent with molestation.

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

- The caregiver or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing the child to observe sexual performances or activities, or sexual trafficking).

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

- There is not a non-offending caregiver, or the non-offending caregiver is not protective (blaming the child for the sexual abuse or the investigation or denying that the sexual abuse occurred) or is otherwise influencing or coercing the child victim regarding disclosure.

- Access to a child by a confirmed sexual abuse perpetrator, especially with known restrictions regarding any child under age 18, exists.

3. Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.

The caregiver is unable or unwilling to address critical areas of food, clothing, shelter, supervision, and/or medical and mental health care for the child AND the child has been seriously harmed or is in imminent danger of being seriously harmed as a result.

- The child's nutritional needs are not met, resulting in danger to the child's health and/or safety, including malnutrition and morbid obesity.

- The child is without clothing appropriate to the weather. Consider the age of the child and whether clothing is the choice of the child or has been provided by the caregiver.

- The caregiver does not seek treatment for the child's immediate, chronic, and/or dangerous medical condition(s), or does not follow prescribed treatment for such conditions, resulting in declining health status (e.g., not providing insulin for a child with diabetes, not providing follow-up care for a wound that is infected, or not providing care for a broken bone).

  Note: The pursuit of traditional or alternative practices rather than prescribed treatment is included here IF there is evidence that the child's health status is declining AND there is evidence that prescribed treatment would likely be effective.

- The child has exceptional needs, such as being medically fragile, which the caregiver does not or cannot meet, resulting in declining health status.

  The child is suicidal and/or is seriously self-harming AND the caregiver will not/cannot take protective action.

- The child shows effects of maltreatment, such as serious emotional symptoms, lack of behavioral control, or serious physical symptoms. This may include situations where a

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child exhibits severe anxiety (e.g., nightmares, insomnia, exhibits fear) related to situations associated with domestic violence.

- The caregiver is present but does not attend to the child to the extent that need for care goes unnoticed or unmet (e.g., can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).

- The caregiver leaves the child alone (time period varies with age and developmental stage) in circumstances that create opportunities for serious harm, e.g., child left unattended in vehicle.

- The caregiver is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) and there are no arrangements for the child that would ensure his/her safety.

- The caregiver makes inadequate and/or inappropriate babysitting or child care arrangements, or demonstrates very poor planning for the child's care during absences, and these arrangements do not provide minimal safety for the child (e.g., temporary caregiver is intoxicated, has limited capacity, or for any reason is unable to meet child's needs).

4. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:

- Leaking gas from stove or heating unit.

- Lack of water or utilities (heat, plumbing, electricity), and no alternative or safe provisions have been made.

- Open/broken/missing windows.

- Exposed electrical wires.

- Excessive garbage or rotted or 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 and other weapons are not locked and not properly secured.

- Drug production in the home.

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- Substances (including drugs, drug paraphernalia or cleaning supplies) or objects within reach of child that may endanger his/her health and/or safety.

5. **Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in severe psychological/emotional harm AND these actions result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.**
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 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 for family problems.
- The caregiver places the child in the middle of a custody battle.

6. **Caregiver is unable OR unwilling to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.**
The caregiver fails 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 or sexual abuse resides in the home, or the caregiver allows access to the child. Include regardless of whether the caregiver (1) knew of the history and allowed access, or (2) upon learning of the history, has not prevented further access.
- The caregiver regularly takes the child to dangerous locations where drugs are manufactured or regularly administered (e.g., meth labs or drug houses), or locations used for prostitution or pornography.
- In circumstances of domestic violence, the non-offending caregiver is not able to protect him/herself or the child from immediate threat of physical and emotional harm.

7. **Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, AND the nature of the injury suggests that the child's safety may be of immediate concern.**
Factors to consider include the child's age, location of injury, exceptional needs of the child, or chronicity of injuries.

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- The injury requires medical attention AND medical assessment indicates the injury is likely to be the result of abuse or is inconsistent with the explanation provided by the caregiver; OR

- There was a suspicious injury that did not require medical treatment but covered multiple parts of the body, appeared to be caused by an object, or is in different stages of healing, AND/OR was located on an infant, or for older children, on the torso, face, or head.

AND one of the following is true:

- The caregiver denies abuse or attributes the injury to accidental causes; OR

- The caregiver's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury; OR

- The caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child.

8. The family refuses access to the child, or there is reason to believe that the family is about to flee.

This safety threat should only be identified when other threats are near, but do not reach the threshold in the definitions; the worker has made attempts to contact the child and been refused access by the caregiver; OR there is reason to believe the family is about to flee during an ongoing investigation after an initial safety assessment has been completed.

- The family currently refuses access to the child or cannot/will not provide the child's location.

- The family has removed the child from a hospital against medical advice to avoid investigation.

- The family has previously fled in response to a CPS investigation or there is credible information that the family is about to flee.

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

9. Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.

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

Previous maltreatment includes any of the following:

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- 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 or bone fracture, subdural hemorrhage or 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 could have caused severe injury, there was retaliation or threatened retaliation against a child for previous incidents, or prior domestic violence resulted in serious harm or threatened harm to a child.

- Prior service failure. Failure to successfully complete court-ordered or voluntary services.

10. **Other (specify).** Circumstances or conditions that pose an immediate threat of serious harm to a child, which are not already described in safety threats 1–9.

Safety Decision

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. Complete the investigation and the risk assessment as required.

SECTION 1A: CAREGIVER COMPLICATING BEHAVIORS

Substance abuse. Caregiver has abused legal or illegal substances or alcoholic beverages in this incident to the extent that control of his/her actions is significantly impaired, or information is available that there has been past abuse of legal or illegal substances.

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Domestic violence. There are indications of a recent history of one or more physical assaults between intimate members of the household, or threats/intimidation or harassment that are known as a result of self-report or other credible report by a family or other household member, friend, other collateral contacts, and/or police reports.

Mental health. One or both caregivers appear to be mentally ill at the time of this incident or have a known history of mental health issues. Caregiver may have a past diagnosis, hospitalization(s), or referrals for observation that are known as a result of self-report or other credible report by a family or other household member, friend, other collateral contacts, and/or police reports.

Developmental/cognitive impairment. One or both caregivers may have diminished capacity as a result of developmental delays or cognitive issues.

Physical condition. One or both caregivers has a physical condition that impacts care and protection of the child in the household.

SECTION 2: HOUSEHOLD STRENGTHS AND PROTECTIVE ACTIONS

Household strengths are resources and coping skills/qualities in an individual or a family that contribute in positive ways to family life but do not, in and of themselves, directly enhance the child's protection from the safety threat(s) over time. These characteristics can be built upon for future planning and indicate the capability to be used in the safety planning process.

Protective actions are specific actions and/or activities that have been taken by the caregiver that directly address the safety threat and are demonstrated over time. These are observed activities that have been demonstrated in the past and can be directly incorporated into the safety plan for the family and child. They may also include actions taken by the child in some circumstances. Actions taken by the child should not be the basis for the safety plan but may be incorporated as part of the plan.

Household Strengths

The following strengths should be assessed, considered, and built upon when creating a safety plan to mitigate the safety threats. Mark all that apply to the household.

At least one caregiver identifies and acknowledges the problem/safety threat(s) and suggests possible solutions. The caregiver demonstrates an understanding of the issues that led to the current safety threats and participates in planning to mitigate the situation by suggesting possible solutions for mitigating the safety threat.

At least one caregiver has at least one supportive relationship with someone who is willing to be a part of his/her support network. The caregiver has a supportive relationship with at least one other family member, neighbor, or friend who may be able to assist in safety planning. This support network member is someone who cares about the child or family but may not, at this time, know what the safety threat is, or has not yet been asked to take action to ensure that the child is protected from those threats now and into the future.

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At least one non-offending caregiver exists and is willing and able to protect the child from future harm. There is at least one caregiver who has done nothing to contribute to the existence of the safety threat. This 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 may be willing to become part of a support network and protect the child going forward.

At least one caregiver is willing to work with the agency to mitigate safety threats, including allowing caseworker(s) access to the child. In the current investigation or assessment, the caregiver allows CPS to have contact with the child for the purpose of assessing child safety. This includes interviews and observation of children in the household. The caregiver accepts the involvement and initial service recommendations of the worker or other individuals working through referred community agencies, including tribal or Indian community service agencies, and/or the use of ICWA program resources. 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 intervention.

At least one child is emotionally/intellectually capable of acting to protect him/herself from a safety threat. At least one child has the intellectual or emotional capacity to ask for help. He/she understands his/her 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).

At least one child is aware of his/her support network members and knows how to contact these individuals when needed. When faced with a potentially dangerous situation, at least one child can currently name adults who care about him/her and who would be able to help him/her in the future. Child also has strategies for how to reach the adults.

Other. Other qualitative actions, resources, and coping demonstrated by the caregiver or family that could be built upon in a safety plan but do not, by themselves, fully address the safety threat.

Protective Actions

The following actions should be assessed, considered, and built upon when creating a safety plan. Mark all that apply to the household.

At least one caregiver articulates specific strategies that, in the past, have been at least partially successful in mitigating the identified safety threat(s), and the caregiver has used or could use these strategies in the current situation. At least one caregiver in the household has been able to protect the child from similar threats in the past through his/her own actions or by using resources. The caregiver is able to describe both the current threats and the strategies he/she is using to mitigate them currently.

At least one caregiver has a stable support network that is aware of the safety threats(s), has been or is responding to the threat(s), and is willing to provide protection for the child. A caregiver regularly interacts, communicates and makes plans with an extended network of family; friends; neighbors; and/or cultural, religious, or other communities that provide support and meet a wide range of needs for the caregiver and/or the child (including tribal ICWA programs, Indian organizations, and/or family members, which can include non-related tribal members). The caregiver has informed these network

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members of the threats and they have assisted in the situation by providing protection to the child (e.g., members of the support network have provided food when needed, assistance to prevent utility shut-off, or a planned safe place for the child to stay in the event of violence in the household; not allowing an offending caregiver to have unplanned forms of contact, etc.).

At least one child, in the past or currently, acts in ways that protect him/herself from a safety threat(s). Prior to the current threat, in response to similar circumstances where a threat has been present or circumstances leading to a threat were escalating, the child has been able to protect him/herself. For example, the child was able to remove him/herself from the situation, called 911 to seek assistance, or was able to find another way to mitigate the safety threat.

At least one child has successfully pursued support, in the past or currently, from a member of his/her support network, and that person(s) was able to help address the safety threat and keep the child safe. When faced with one of the safety threats, the child was able to seek help from and receive the necessary assistance from someone in the identified support network (e.g., family members, friends, professionals) AND can currently name adults who care about him/her and would be able to help if a similar situation arose in the future.

Other. Other actions of protection taken by the caregiver, a household member, safety network member, and/or the child, which mitigate one or more of the safety threats.

SECTION 3: IN-HOME PROTECTIVE INTERVENTIONS

Safety Decision

Safe with plan. One or more safety threats are present; however, the child can safely remain in home with a safety plan. In-home protective interventions have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Mark all in-home interventions used in the safety plan.

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes. Follow county policies whenever applying any of the safety interventions.

1. **Intervention or direct services by worker. (DO NOT include the investigation itself.)**
   Actions taken or planned by the investigating worker or other CPS staff that specifically address one or more safety threats. Examples include: providing information about nonviolent 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 restraining orders; and providing definitions of child abuse laws and informing involved parties of the consequences of violating these laws. DOES NOT INCLUDE the investigation itself or services provided to respond to family needs that do not directly affect safety.

2. **Use of family, neighbors, or other individuals in the community as safety resources.**
   This includes applying the family's own strengths as resources to mitigate safety concerns or using extended family members, neighbors, or other individuals to mitigate safety concerns.

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Examples include: family's agreement to use nonviolent means of discipline; 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 12-step sponsor to meet with the caregiver daily and call the worker if the caregiver has used or missed a meeting;

OR

The caregiver's decision, *as part of a safety plan*, to have the child cared for by a friend or relative for a limited period of time, such as overnight or for a few days.

3. **Use of community agencies or services as safety resources.**
Involving a community-based or faith-related organization or other agency in activities to address immediate safety threats (e.g., using a local food pantry). DOES NOT INCLUDE long-term therapy or treatment, or being put on a waiting list for services.

4. **Use of tribal, Indian community service agency, and/or ICWA program resources.**
This includes but is not limited to:

- Use of tribal family services from the child's/caregiver's tribe or a tribal consortium;
- Indian resource centers;
- Indian health clinics;
- Tribal TANF (Temporary Assistance for Needy Families);
- Title VII Indian education programs, which may not be affiliated with a tribe; and
- A county-based dedicated Indian specialist or service unit.

5. **Have the caregiver appropriately protect the victim from the alleged perpetrator.**
A non-offending caregiver has acknowledged the safety threats and is able and willing to protect the child from the alleged perpetrator. A non-offending caregiver who had prior knowledge of the alleged perpetrator's actions but took no action prior to the safety assessment should not be the only safety resource or intervention. Examples include agreement that the child will not be alone with the alleged perpetrator or agreement that the caregiver will restrain the alleged perpetrator from physical discipline of the child.

6. **Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.**
Temporary or permanent removal of the alleged perpetrator. Examples include: arrest of alleged perpetrator, non-perpetrating caregiver "kicking out" alleged perpetrator who has no legal right to the residence, or the alleged perpetrator agrees to leave.

7. **Have the non-offending caregiver move to a safe environment with the child.**
A caregiver not suspected of harming the child has taken or plans to take the child to an alternative location where the alleged perpetrator will not have access to the child. Examples include a domestic violence shelter, home of a friend or relative, or hotel.

8. **Legal action planned or initiated—child remains in the home.**
Legal action has already commenced, or will be commenced, that will immediately and effectively mitigate identified safety threats and is identified in the safety plan. This includes family-initiated actions (e.g., restraining orders, mental health commitments, change in

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custody/visitation/guardianship) and CPS-initiated actions (file petition and child remains in the home). This includes actions taken by the child's tribe and tribal court to intervene or take jurisdiction of the Indian child's case.

9. Other (specify).
The family or worker identifies a unique intervention for an identified safety concern that does not fit within items 1–8.

SECTION 4: PLACEMENT INTERVENTIONS

Safety Decision

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

10. Have the caregiver voluntarily place the child outside the home, consistent with WIC § 11400 (o) and (p).
A voluntary agreement is signed between the caregiver and the CPS agency to place the child in an approved resource family placement, tribally approved home, or tribally specified home, and the caregiver is cooperating with the agency to provide needed consents and information to fund this voluntary placement. This voluntary agreement is consistent with Welfare and Institutions Code (WIC) § 11400 (o) and (p). The caregiver understands that if he/she withdraws consent for voluntary placement and identified safety threats are still present, other interventions to ensure the child's safety will need to be considered.

11. Child placed in protective custody because interventions 1–10 do not adequately ensure the child's safety.
One or more children are protectively placed pursuant to WIC § 309 and are entitled to notice and a hearing within 72 judicial hours.

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CALIFORNIA
SDM® REUNIFICATION REASSESSMENT
POLICY AND PROCEDURES

The purpose of the reunification reassessment is to help assess whether children in placement who have a reunification goal should:

1. Be returned home to the removal household or another household with a legal right to placement; or

2. Be maintained in placement while reunification services continue; or

3. Have a permanency alternative implemented and reunification services terminated.

Research indicates that children are less likely to suffer subsequent harm and re-enter care when the recommendations of the reunification reassessment are followed.

Which Cases: All ongoing cases in which at least one child is in placement with a goal of return home. If more than one household is receiving reunification services, complete one assessment on each household.

Who: The ongoing worker.

When: *Prior to each status review hearing and/or Division 31 required review, which occurs at least once every six months, and prior to a recommendation to return a child to the removal home, continue FR, or terminate FR services. To ensure that current SDM assessments are available, they should be completed:*

No more than 65 calendar days prior to completing each case plan or recommending reunification or change in permanency planning goal.

Should be completed sooner if there are new circumstances or new information that would affect risk.

Decision: The reunification reassessment guides the decision to:

1. Return a child to the removal household* or to another household with a legal right to placement (non-removal household);

2. Maintain out-of-home placement; and/or

3. Terminate reunification services and implement a permanency alternative.

*Removal household is that household from which the child was removed, or, if due to joint custody that designation is unclear, then the household where the most serious maltreatment occurred. Non-removal households are those households other than the removal household with legal rights to the child (father's home, mother's home).

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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 case plan should be shared with the household at the beginning so that the household understands what is expected. The reunification reassessment form should be shared with the household at the same time so that the family members understand exactly what will be used to evaluate reunification potential and the threshold they must reach. Specifically:

- Inform the family of their original risk level, and explain that this will serve as the baseline for the reunification reassessment (unless a new referral is received, in which case the new risk level will be used).

- Explain that a new substantiated investigation or failure to progress toward case plan goals will increase their risk level, and that progress toward case plan goals will reduce their risk level.

- Explain that both the quantity and quality of their visitation with the child will be considered, and that they must attend at least 65% of their visits and those visits must have at least adequate quality (provide the definition for adequate quality).

- Provide information on the reunification safety assessment and explain that if everything else would permit reunification, the final consideration is safety. They must demonstrate that the safety threats that led to placement have either been mitigated or can be controlled by a safety plan, and that either no safety threats are currently present or there is a safety plan in place to address any identified safety threats.

For each household participating in reunification services, using the definitions and instructions, complete the following.

A. REUNIFICATION RISK REASSESSMENT
Complete all risk items using the definitions, determine the scored risk level, consider overrides, and determine the final risk level.

B. VISITATION PLAN EVALUATION
Complete the visitation plan evaluation for each child in the household, using the definitions, and consider overrides for each child. It is recommended that efforts be made to behaviorally describe visitation quality within the family's case plan relevant to the specific safety threats, risk factors, and underlying family functioning that account for the children being in out-of-home care.

C. REUNIFICATION SAFETY ASSESSMENT
Complete the safety assessment if required by the results of the reunification risk reassessment and visitation plan evaluation. Risk must be either low or moderate and visitation must be acceptable. Consider how the safety threats that led to removal have been mitigated; whether additional safety threats have been identified since removal and if so, whether those threats have been mitigated; or if current safety threats can be controlled in-home through a safety plan. Note that safety threat items

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that should be assessed when considering any new threat in the home are the same as on the original safety assessment, but may have slight variations to reflect the decision at hand.

D. PLACEMENT/PERMANENCY PLAN GUIDELINES

After completing the reunification risk reassessment, visitation plan evaluation, and reunification safety assessment (if indicated), select the appropriate decision tree, based on the child's age at the time of removal.

Begin at the top of the tree. Proceed to the left if the reunification risk level is high or very high, and to the right if the reunification risk level is low or moderate.

Continue following the pathway answering all questions until a termination point is reached. Termination points include:

- Return home
- Continue family reunification services
- Terminate family reunification services; implement permanency alternative

OVERRIDES

Consider whether any overrides are applicable, using the definitions. If no overrides apply, mark "No overrides 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. Provide explanation where required.

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Appendix

Family Strengths and Needs Assessment/Case Management System Service Objectives Map

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CALIFORNIA
FAMILY STRENGTHS AND NEEDS ASSESSMENT/CASE MANAGEMENT SYSTEM
SERVICE OBJECTIVES MAP

Instructions: After identifying priority needs using the SDM family strengths and needs assessment (FSNA), locate each priority need in column one. Identify the service objective(s) from column two that best apply to this family (service objectives are those appearing in the CWS/CMS drop-down menu). Items in boldface directly and/or fully correspond to items on the FSNA. The other items indirectly and/or partially correspond to items on the FSNA.

When you open the CWS/CMS service objectives drop-down menu, you may click on the objectives selected.

If you are completing the "contributing factor" and/or "strength" screens in CWS/CMS, proceed as above, using the corresponding columns in this table.

FSNA Priority Need	Service Objective (select one or more, as appropriate)	Contributing Factor	CWS/CMS Strength
SN7. Substance Use	**Do not abuse alcohol.** **Do not abuse drugs.** Able and willing to have custody. Acquire adequate resources. Do not neglect your child's needs. Do not physically abuse your child. Do not sexually abuse your child. Eliminate danger to physical health. Have no contact with child. Improve basic self-care, grooming, dressing, and hygiene. Monitor child's health, safety, and well-being. Obtain/maintain legal source of income.	**Parent skills hindered by alcohol abuse.** **Parent skills hindered by drug abuse.** Child born with drugs in his/her system. Child has no caregiver. Parent unable/unwilling to supervise child.	**Free from alcohol/drug dependency.** Appropriate involvement with child.
SN5. Household and Family Relationships SN6. Domestic Violence	**Develop supportive interpersonal relationships (detail should describe application to household).** Control anger/negative behavior. Treat others with respect. Protect yourself from abusive partner.	Family boundaries rigid/punitive. Minor mother cannot live with parents. Parent does not control anger. Parent has no support system (specify within home). Parent has unsafe associations/activities in home. Parent is codependent and affects parenting. Parent lacks conflict resolution skills. Parent unable to cope due to family/personal crisis. Family lacks a safe home. Parent has a history of abusive behavior. Parent has a history of being abused.	Absent parent supportive. Insight into family problems. Intact family. Motivated to solve problems. Willingness to change.

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FSNA Priority Need	Service Objective (select one or more, as appropriate)	Contributing Factor	CWS/CMS Strength
SN4. Social Support System	**Develop supportive interpersonal relationships (detail should describe application to extended family and community).** Acquire adequate resources. Arrange child care/support during your absence.	**Parent has no support system.** **Child at risk due to isolation by caregiver.**	**Community support utilized.** **Extended family/friend support.** Social skills.
SN3. Parenting Practices	**Do not neglect your child's needs.** **Do not physically abuse your child.** **Do not sexually abuse your child.** **Do not use physical punishment.** **Provide appropriate/adequate parenting.** Able and willing to have custody. Ensure school attendance. Know age-appropriate expectations. Monitor/correct child's behavior. Monitor child's health, safety, and well-being. Positive interaction with child during visits. Protect child from contact with abuser. Protect child from emotional harm. Protect child from physical abuse. Protect child from sexual abuse. Provide care for child's special needs. Provide emotional support for child.	**Abusive behavior indicates escalating risk.** **Parent lacks parenting skills.** Lack of parent/child bonding/ involvement. Parent developmental disability hinders ability to parent. Parent mental health hinders ability to parent. Parent skills hindered by alcohol abuse. Parent skills hindered by drug abuse. Parent skills hindered by immaturity. Parent is codependent, which affects parenting. Parenting role reversal between parent and child. Parent unable/unwilling to supervise child.	**Parenting skills.** Appropriate involvement with child. Awareness of age-appropriate development. Disciplines appropriately. Good parent/child bonding. Realistic expectations of child.
SN8. Mental Health/ Coping Skills	**Stabilize mental health.** Able and willing to have custody. Improve basic self-care, grooming, dressing, and hygiene. Take responsibility for actions.	**Parent mental health hinders ability to parent.** **Parent unable to cope due to family/ personal crisis.** Child has no caregiver. Parent has poor impulse control. Parent is codependent, which affects parenting. Parent unable/unwilling to supervise child.	**Emotionally healthy.** Goal setting/planning skills. Insight into family problems. Motivated to solve problems. Positive attitude. Self-esteem.

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FSNA Priority Need	Service Objective (select one or more, as appropriate)	Contributing Factor	CWS/CMS Strength
SN1. Resource Management/ Basic Needs	**Acquire adequate resources.** **Maintain suitable residence for child.** **Obtain/maintain legal source of income.** Able and willing to have custody. Acquire basic cooking skills. Acquire basic skills to seek employment. Acquire shopping, budgeting, and money management skills. Do not neglect your child's needs. Eliminate danger to physical health. Improve basic self-care, grooming, dressing, and hygiene. Provide care for child's special needs. Will complete vocational training.	**Family has no income.** **Family lacks a safe home.** **Parent has inadequate resources to meet needs.** Lack of housekeeping knowledge/skills. Parent has lack of job skills.	**Housing adequate.** **Income source adequate.** Child care adequate. Clean/safe home and yard. Employed. Medical care adequate. Personal hygiene adequate. Transportation available.
SN2. Physical Health	**Eliminate danger to physical health.** **Improve basic self-care, grooming, dressing, and hygiene (detail should describe application to self-physical care).** Able and willing to have custody.	**Parent unable to cope due to family/personal crisis.** **Parent unable/unwilling to supervise child.**	**Physically healthy.** Medical care adequate.
SN9. Trauma	**Other Service Objective—trauma-specific description.** **Protect self from abusive relationships.** **Control anger/negative behavior.** **Develop supportive interpersonal relationships.** **Take responsibility for actions.** **Provide emotional support for child.** Allow victim confrontation. Positive interaction during child visits. Protect child from contact with abuser. Protect child from emotional harm.	**Parent was abused as a child.** **Parent unable to cope due to family/personal crisis.**	**Emotionally healthy.** **Insight into family problems.** **Parent's childhood needs were met adequately.** **Self-esteem.**
SN10. Cognitive/ Developmental Abilities	**Able and willing to have custody.** **Monitor child's health, safety, and well-being.** Develop supportive interpersonal relationships. Do not neglect your child's needs. Know age-appropriate expectations.	**Parent developmental disability hinders ability to parent.**	**Willingness to accept services.**

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FSNA Priority Need	Service Objective (select one or more, as appropriate)	Contributing Factor	CWS/CMS Strength
CSN1. Emotional/Behavioral	**Monitor/correct child's behavior.** **Provide emotional support for child.** **Stabilize mental health.** Accept disclosure made by child. Child to abide by placement rules. Child to cooperate with child welfare worker. Control anger/negative behavior. Improve basic self-care, grooming, dressing, and hygiene. Maintain problem-free school behavior. Monitor child's health, safety, and well-being. Protect child from emotional harm. Provide care for child's special needs. Take responsibility for actions. Treat others with respect.	**Child's behavior threatens siblings.** **Child's behavior affects parent's ability to cope.** Child born with drugs in his/her system. Child's associations affect parent's ability to supervise child.	**Emotionally healthy.** Positive attitude. Self esteem.
CSN7. Physical Health/ Disability	**Provide care for child's special needs.** **Eliminate danger to physical health.** **Monitor child's health, safety, and well-being.** Able and willing to have custody. Arrange child care during your absence (detail should describe application to specialized care). Do not neglect your child's needs (medical/health needs).	**Child's disability affects parent's ability to cope.** Child born with drugs in his/her system. Parent has inadequate resources to meet needs. Parent not cooperating (with medical treatment) indicates risk to child. Parent unable to cope due to family/personal crisis.	**Medical care adequate.** **Physically healthy.** Child care adequate.
CSN4. Education	**Ensure school attendance.** **Attend school regularly.** **Complete homework.** Prepare for independent living. Will complete vocational training. Will remain in school until graduation.	Child's behavior affects parent's ability to cope.	**Child doing well in school.**

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FSNA Priority Need	Service Objective (select one or more, as appropriate)	Contributing Factor	CWS/CMS Strength
CSN6. Family Relationships	**Develop supportive interpersonal relationships.** Accept disclosure made by child. Allow victim confrontation. Control anger/negative behavior. Have no contact with child. Positive interaction during child visits. Refrain from domestic violence. Treat others with respect.	**Child has no caregiver.** **Family boundaries rigid/punitive.** **Lack of parent/child bonding/ involvement.** Child at risk due to isolation by caregiver. Minor mother cannot live with parents. Parent has unsafe associations/activities in home. Parent is codependent, which affects parenting. Parent lacks conflict resolution skills. Parenting role reversal between parent and child.	**Appropriate involvement with child.** **Good parent/child bonding.** **Relates appropriately to parents/adults.** Insight into family problems. Intact family. Absent parent supportive.
CSN3. Child Development	**Provide care for child's special needs.** Know age-appropriate expectations. Prepare for independent living.	**Child's disability affects parent's ability to cope.** **Parent unable/unwilling to supervise child.** Child born with drugs in his/her system. Child at risk due to isolation by caregiver. Lack of hygiene knowledge/skills. Parent has inadequate resources to meet needs. Parent has no support systems.	**Awareness of age-appropriate development.** Personal hygiene adequate. Realistic expectations of child.
CSN8. Alcohol/Drugs	**Do not use drugs.** **Do not use alcohol.**	**Child's behavior affects parent's ability to cope.** Child's associations affect parent's ability to supervise child.	**Free from alcohol/drug dependency.**
CSN5. Social Relationships	**Develop supportive interpersonal relationships.** Control anger/negative behavior. Positive interaction during child visits. Treat others with respect.	**Child's associations affect parent's ability to supervise child.** Child at risk due to isolation by caregiver.	**Social skills.**
CSN9. Delinquent Behavior	**Do not break the law.** Comply with court orders. Control anger/negative behavior. Take responsibility for actions.	**Child's behavior affects parent's ability to cope.** Child's associations affect parent's ability to supervise child.	**Law-abiding.** Willingness to change.

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FSNA Priority Need	Service Objective (select one or more, as appropriate)	Contributing Factor	CWS/CMS Strength
CSN2. Trauma	**Other Service Objective—trauma-specific description.** **Protect self from abusive relationships.** **Control anger/negative behavior.** **Develop supportive interpersonal relationships.** Allow victim confrontation. Protect child from contact with abuser. Protect child from emotional harm. Provide care for child's special needs.	**Harmful relationships.** **Parent has a history of abusive behavior.**	**Child shows comfort in parent's presence.** **Emotionally healthy.** **Parent shows empathy for the child.** **Self-Esteem.**
CSN10.Relationship with Substitute Caregiver	**Develop supportive interpersonal relationships.** Child to abide by placement rules.	**Child has no caretaker.**	**Relates appropriately to parents/adults.** **Appropriate involvement with the child.** **Good parent/child bonding.** **Parent raised child a significant time.**
CSN11. Independent Living	**Prepare for independent living.** Will complete vocational training. Will remain in school until graduation/GED. Protect self from abusive relationships. Improve basic self-care, grooming, dressing, and hygiene. Develop supportive interpersonal relationships. Acquire shopping, budgeting, money management skills. Acquire basic skills to see employment. Acquire basic cooking skills. Acquire adequate resources.	Disconnected from cultural/community identity. Lack of housekeeping knowledge and skills. Limited skills. Delinquent behavior.	**Child doing well in school.** **Goal setting/planning skills.** **Child shows age-appropriate development.** **Cooperative.** **Relates appropriately to parents/adults.**

Process Objectives

Comply with visitation.
Maintain placement with potential legal guardian.
Maintain long-term placement for the child.
Obtain/finalize adoption.
Obtain/finalize guardianship requirements.

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