EVIDENT CHANGE
Inform Systems. Transform Lives.

SDM® ONGOING TOOLS PROCEDURE MANUAL

Division of Children and Family Services

March 2025

ABOUT EVIDENT CHANGE

Evident Change is a nonprofit that uses data and research to improve our social systems. For more information, call (800) 306-6223 or visit EvidentChange.org. You can also find us on social media by visiting Linktr.ee/EvidentChange.

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SDM GENERAL DEFINITIONS

SDM assessments are completed on households where there have been screened-in child abuse and/or neglect allegations (with the exception of the hotline assessment, which is completed for referrals). The following general definitions apply when completing the SDM assessments beyond screening.

FAMILY

Caregivers; adults fulfilling the caregiver role; guardians; children; and others related by ancestry, adoption, or marriage; or as defined by the family itself.

HOUSEHOLD

All persons who have significant in-home contact with the child, including those who may not actually live there but have a familial or an intimate relationship with any person in the home.

PRIMARY AND SECONDARY CAREGIVER

When answering some items on the risk assessment, it is necessary to consistently identify a primary and a secondary caregiver. Select a primary and secondary caregiver from among the household members using the caregiver identification flowchart below, beginning at the top and working down until the primary and secondary caregivers can be identified. If the child's legal parents live in separate households, *each* household will have a primary (and possibly secondary) caregiver who is one of the people residing in that household.

CAREGIVER

- A person who is responsible for a child's care, custody, or welfare, such as:
- A parent, guardian, or managing or possessory conservator;
- Another adult member of the child's family or household; or
- A person with whom the child's parent cohabits.

Use the caregiver identification flowchart below to distinguish between the primary and secondary caregiver for the risk assessment.

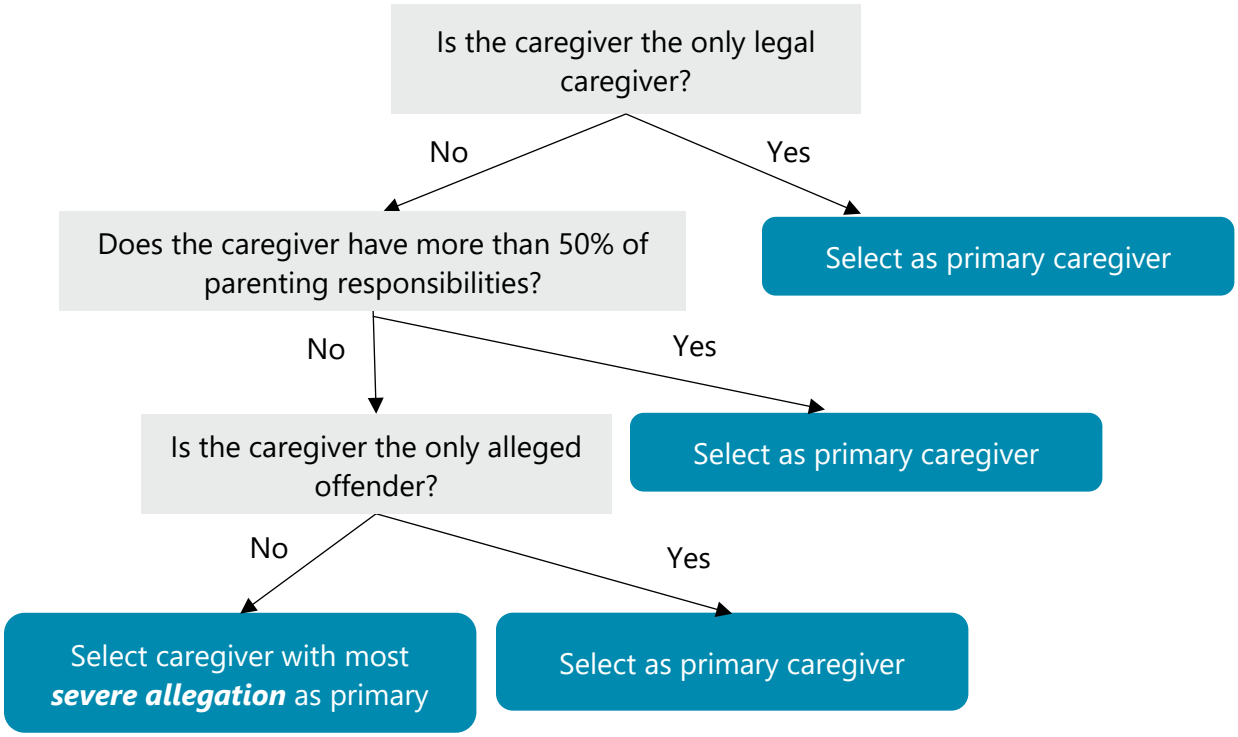
ADDITIONAL CONSIDERATIONS

A minor may be the primary or secondary caregiver if they are the biological parent of the alleged victim child. A minor is anyone under the age of 18. This does not include a child who has been legally emancipated and lives separately from their parents.

A minor may never be considered the primary or secondary caregiver of their sibling.

CAREGIVER IDENTIFICATION FLOWCHART

For each household in which a child is a member, distinguish between primary and secondary caregivers according to the following criteria.



Note: If both caregivers have the same allegation, just pick one; the risk level is likely to be the same for both caregivers.

SDM® FAMILY CASE PLAN TOOL

ARKANSAS DIVISION OF CHILDREN AND FAMILY SERVICES

Family Name: _____ **Case #:** _____

Assessment Date: _____

Assessment type: ○ Initial ○ Reassessment ☐ 1 ☐ 2 ☐ 3 ☐ 4

County: _____

Worker Name: _____ **Household Assessed:** _____

SECTION 1: CAREGIVER STRENGTHS AND NEEDS ASSESSMENT

Primary Caregiver Name: _____

Is there a secondary caregiver? ○ Yes ○ No **Secondary Caregiver Name:** _____

A. HOUSEHOLD CONTEXT

Personal characteristics, traditions, beliefs, and values important to caregiver:

The caregiver has the following perspective on their personal characteristics, traditions, beliefs, and values.

Note that P=primary caregiver, S=secondary caregiver.

P	S	
○	○	a. Community connectedness is a source of significant strength.
○	○	b. Community connectedness is a source of some strength.
○	○	c. Lack of community connectedness results in difficulties.
○	○	d. Lack of community connectedness results in significant difficulties.

Consider how the family's personal characteristics, traditions, beliefs, values, and past and current experiences may influence or shape parenting and caregiving. Are there contacts or services within this context that can be used in the family case plan to enhance safety now or over time?

B. CAREGIVER AREAS

Indicate whether the caregiver's behaviors in each area (a) actively help create safety, permanency, or well-being for the child; (b) are neither a strength nor a need in child safety, permanency, or well-being; (c) make it difficult to create long-term safety, permanency, or well-being (i.e., are a need); 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."

SN1. Resource Management/Basic Needs

P	S	
○	○	a. Resources are consistently managed in a manner sufficient to meet the basic needs of household members.
○	○	b. Resources may be limited but are adequately managed.
○	○	c. Resources are insufficient, not well managed, or illegally obtained.
○	○	d. Resources are severely limited and/or mismanaged, or there are no legal resources.

SN2. Physical Health

P	S	
○	○	a. Preventative health care is practiced.
○	○	b. Health concerns or disabilities do not affect family functioning.
○	○	c. Health concerns or disabilities affect family functioning.
○	○	d. Serious health concerns or disabilities result in inability to care for the child.

SN3. Parenting Practices

P	S	
○	○	a. Strong skills
○	○	b. Adequately parents and protects the child
○	○	c. Inadequately parents and protects the child
○	○	d. Destructive/abusive parenting

SN4. Social Support System

P	S	
○	○	a. Strong support system
○	○	b. Adequate support system
○	○	c. Limited support system
○	○	d. No support system

SN5. Household Relationships

P	S	
○	○	a. Actively help create safety, permanency, and child well-being
○	○	b. Are not strengths or needs for safety, permanency, or child well-being
○	○	c. Are needs for safety, permanency, or child well-being
○	○	d. Contribute to imminent risk of serious physical or emotional harm to the child

SN6. Intimate Partner Violence

P	S	
○	○	a. Actively help create safety, permanency, and child well-being
○	○	b. Are not strengths or needs for safety, permanency, or child well-being
○	○	c. Are needs for safety, permanency, or child well-being
○	○	d. Contribute to imminent risk of serious physical or emotional harm to the child

SN7. Substance Use

P	S	
○	○	a. Demonstrates healthy knowledge of and behavior related to alcohol and drugs
○	○	b. Alcohol or prescribed drug use/no use
○	○	c. Alcohol or drug misuse
○	○	d. Chronic alcohol or drug misuse

SN8. Mental Health

P	S	
○	○	a. No mental health concerns
○	○	b. Mental health concerns being managed effectively
○	○	c. Mild to moderate symptoms
○	○	d. Chronic/severe symptoms

SN9. Prior Adverse Experiences/Trauma

P S

- ○ ○ a. Experienced at least one traumatic event AND maintained or resumed daily functioning
- ○ ○ b. No known traumatic experiences or symptoms
- ○ ○ c. Experienced some trauma and has some symptoms
- ○ ○ d. Experienced traumatic event and has significant symptoms

SN10. Coping Skills

P S

- ○ ○ a. Has strong coping skills and uses them
- ○ ○ b. Has adequate coping skills and uses them
- ○ ○ c. Has minimal coping skills and rarely uses them
- ○ ○ d. No coping skills

SN11. Cognitive/Developmental Abilities

P S

- ○ ○ a. Consistently demonstrates an understanding of complex information and applies information to solve difficult problems
- ○ ○ b. Understands essential information and applies information to problems
- ○ ○ c. Some difficulty understanding or applying essential information
- ○ ○ d. Substantial inability to understand or apply essential information

SN12. Other Identified Caregiver Strength or Need (not covered in SN1 – SN11)

☐ Not applicable

An additional need or strength has been identified that:

P S

- ○ ○ a. Actively helps create safety, permanency, and child well-being
- ○ ○ b. Is not a strength or need for safety, permanency, or child well-being
- ○ ○ c. Is a need for safety, permanency, or child well-being
- ○ ○ d. Contributes to imminent risk of serious physical or emotional harm to the child

Description of behaviors

C. PRIORITY NEEDS AND STRENGTHS

Enter the item number and name of all of the most serious needs ("d"s first, then "c"s) from items SN1 – SN12 for each caregiver. 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)	**AREA NUMBER/NAME**	**CAREGIVER**	**PRIORITY FOR CLOSURE? (Required if Answer Is "d")**
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No

Enter the item number and description of all of the family's strengths ("a" answers) from items SN1 – SN12 for each caregiver. These family strengths can be used to address the priority needs identified above.

STRENGTHS			
SCORE ("a"s)	**AREA NUMBER/NAME**	**CAREGIVER**	**INCLUDE IN FAMILY CASE PLAN?**
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No
		O Primary O Secondary O Both	O Yes O No

SECTION 2: CHILD STRENGTHS AND NEEDS ASSESSMENT

Repeat this section for each child in the household.

Child Name: _____ **Child Birth Date:** _____

Personal characteristics, traditions, beliefs, and values important to child:

A. HOUSEHOLD CONTEXT

The child's perspective is that personal characteristics, traditions, beliefs, and values:

- ○ a. Help them create safety, permanency, and well-being for themself
- ○ b. Have no effect on their safety, permanency, or well-being
- ○ c. Make it difficult for them to experience long-term safety, permanency, or well-being
- ○ d. Contribute to imminent risk of serious physical or emotional harm to the child

Consider how the child's personal characteristics, traditions, beliefs, values, and past and current experiences may influence them. Are there contacts or services within this context that can be used in the family case plan?

B. CHILD AREAS

Indicate whether the behaviors of the child in each area (a) actively help create safety, permanency, or well-being for themself; (b) are neither a strength nor a need for their safety, permanency, or well-being; (c) make it difficult to create long-term safety, permanency, or well-being (i.e., are a need); or (d) directly contribute to a safety threat.

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

CSN1. Emotional/Behavioral Health

- ○ a. Strong emotional/behavioral adjustment
- ○ b. Adequate emotional/behavioral adjustment
- ○ c. Limited emotional/behavioral adjustment
- ○ d. Severely limited emotional/behavioral adjustment

CSN2. Trauma

- ○ a. The child's response to prior trauma contributes to their safety.
- ○ b. The child has not experienced trauma; OR the child has experienced trauma, but no additional intervention is needed.
- ○ c. The child's response to prior trauma is a concern, AND it is an ongoing unmet need.
- ○ d. The child's response to prior trauma is a concern that directly contributes to danger to the child.

CSN3. Child Development

- ○ a. Advanced development
- ○ b. Age-appropriate development
- ○ c. Limited development
- ○ d. Severely limited development

CSN4. Education

- ○ a. Outstanding academic achievement
- ○ b. Satisfactory academic achievement OR the child is not of school age
- ○ c. Academic difficulty
- ○ d. Severe academic difficulty

Also indicate if:

- ☐ The child has an individualized education plan.
- ☐ The child has an educational surrogate parent.
- ☐ The child needs an educational surrogate parent.
- ☐ The child is required by law to attend school but is not attending.
- ☐ None of these apply.

CSN5. Social Relationships

- ○ a. Strong social relationships
- ○ b. Adequate social relationships
- ○ c. Limited social relationships
- ○ d. Poor social relationships

CSN6. Physical Health

- ○ a. No health care needs or disabilities
- ○ b. Minor health problems or disabilities that are being addressed with minimal intervention and/or medication
- ○ c. Health care needs or disabilities that require routine interventions
- ○ d. Serious health/disability needs that require ongoing treatment and interventions by professionals or trained caregivers AND/OR has a current unmet medical need

CSN7. Alcohol/Drugs

- ○ a. Actively chooses an alcohol- and drug-free lifestyle.
- ○ b. No use or some use
- ○ c. Alcohol or other drug use
- ○ d. Chronic alcohol or other drug use

CSN8. Delinquent Behavior

- ○ a. No delinquent behavior
- ○ b. No current or recent delinquent behavior
- ○ c. Occasional delinquent behavior
- ○ d. Significant delinquent behavior

CSN9. Family of Origin Relationships

- ○ a. Nurturing/supportive relationships
- ○ b. Adequate relationships
- ○ c. Strained relationships
- ○ d. Harmful relationships

CSN10. Relationship With Substitute Care Provider (if child is in care)

- ○ Not applicable; child is not in care.
- ○ a. Strong relationships with substitute care provider
- ○ b. Adequate relationships with substitute care provider
- ○ c. Limited relationships with substitute care provider
- ○ d. Serious conflicts with substitute care provider

CSN11. Transitional Youth Services (if age 14 or older)

○ Not applicable.

○ a. Prepared to function as an adult

○ b. Making progress toward being prepared for adulthood

○ c. Attempting to prepare for adulthood but lacks the confidence, emotional maturity, and/or sufficient skills to live independently

○ d. Not prepared or is refusing to prepare for adulthood

For child age 14 or older, select all that apply to preparation for adulthood.

☐ Youth has been referred to a Transitional Youth Services Coordinator.

☐ Youth has received and signed Youth Acknowledgement of Rights in Foster Care, and the rights contained in the Youth Rights in Foster Care—The Short List and Be Your Own Advocate documents have been explained to the youth in an age-appropriate way.

☐ A Transitional Team has been developed.

☐ A Life Plan has been completed.

☐ The life skills assessment has been completed.

☐ The youth has been invited to attend life skills classes.

☐ Youth has been informed that they have the right to participate in the extended foster care program after reaching age 18 and until the age of 21 (or any other age as may be required under federal law).

☐ If youth is planning to exit care, a Final Transitional Team meeting has been held 90 or more days prior to the planned exit date.

☐ For youth age 18 or older, an extended foster care budget has been completed.

☐ Youth is participating in the extended foster care program.

☐ None of these apply.

CSN12. OTHER IDENTIFIED CHILD STRENGTH OR NEED (NOT COVERED IN CSN1 – CSN11)

○ Not applicable

An additional need or strength has been identified that:

○ a. Actively helps them create safety, permanency, and well-being for themself

○ b. Is not a strength or need for their safety, permanency, or well-being

○ c. Is a need for their safety, permanency, or well-being

○ d. Contributes to imminent risk of serious physical or emotional harm to the child

Description of behaviors:

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

NEEDS	
SCORE ("d"s, then "c"s)	**AREA NUMBER/NAME**

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

STRENGTHS		
SCORE ("a"s)	**AREA NUMBER/NAME**	**INCLUDE IN FAMILY CASE PLAN?**
		O Yes O No
		O Yes O No
		O Yes O No
		O Yes O No
		O Yes O No
		O Yes O No
		O Yes O No

DEFINITIONS

SECTION 1: CAREGIVER STRENGTHS AND NEEDS ASSESSMENT

A. HOUSEHOLD CONTEXT

Systems of shared actions, values, beliefs, and traditions guide the behavior of families and communities. These systems may be related to a family member's personal characteristics, such as race, ethnicity, tribal affiliation, gender, religious/spiritual affiliation, disability, or other social characteristic.

Family members may be affiliated with multiple systems or groups, and what matters most to a person's self-image may shift with different contexts. For example, a caregiver who is disabled may strongly connect to that characteristic in certain situations, while in other situations their religious affiliation may be more relevant.

Connecting traditions, values, personal characteristics, and caregiving/parenting:

Consider how the family's traditions, values, personal characteristics, norms, and past and current experiences may influence caregiving.

In particular, consider:

- How the caregiver identifies themself demographically;
- Any past or current experiences that are important or relevant to this caregiver; and
- Any coping skills, strengths, and survival skills this caregiver has developed or demonstrated in facing challenges.

How do all of the above influence or shape the caregiver's beliefs about parenting or child-rearing? How do all of the above influence or shape the caregiver's actions with their children?

The caregiver's perspective of community connectedness and personal characteristics:

a. *Community connectedness is a source of significant strength*. The caregiver's connection to and/or involvement with their community is a source of significant strength and support. This includes access to people, networks, organizations, and services from the community.
b. *Community connectedness is a source of some strength*. The caregiver's connection to and/or involvement with their community is a source of some strength and support. This includes access to people, networks, organizations, and services from the community.
c. *Lack of community connectedness results in difficulties*. The caregiver is disconnected from their community AND/OR is experiencing adjustment, and this results in some difficulties. These can include (but are not limited to) social isolation; alienation; impacts on self-image, self-esteem,

resilience, or emotional well-being; and/or conflicts in family and other relationships. If applicable, please refer to Indian Child Welfare Act (ICWA) policy.

d. *Lack of community connectedness results in significant difficulties*. The caregiver is disconnected from their community AND/OR is experiencing adjustment, and this results in significant difficulties. These can include (but are not limited to) social isolation; alienation; impacts on self-image, self-esteem, resilience, or emotional well-being; and/or conflicts in family and other relationships. If applicable, please refer to ICWA policy.

B. CAREGIVER AREAS

Each of the areas 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. There may be some overlap or interaction between areas (e.g., a need in the area 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 area as it relates to their ability to effectively provide for the child'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's health and safety.

a. *Resources are consistently managed in a manner sufficient to meet the basic needs of household members*. 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. *Resources may be limited but are adequately managed*. 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.

   OR

   The caregiver may have limited or no income, but caregiver is able to secure assistance independently (e.g., use of food pantries, Temporary Assistance for Needy Families/TEA, Supplemental Nutrition Assistance Program/food stamps) that will be sufficient for the long term (i.e., caregiver has a plan for the foreseeable future).

c. *Resources are insufficient, not well managed, or illegally obtained*. The main source of income in the house is from illegal activity (drug trade, criminalized sex work, theft, etc.). The caregiver provides housing, but it does not meet the child's basic needs due to conditions such as inadequate plumbing, heating, wiring, or housekeeping. The caregiver does not adequately manage available resources. Food and/or clothing do not meet the child's basic needs.

d. *Resources are severely limited and/or mismanaged, or there are no legal resources*. Considering the child's age and vulnerability, conditions related to resources 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;
- No food, food is spoiled, or family members are malnourished;
- Child chronically presents with clothing that is unclean, not appropriate for weather, or in poor repair to the extent that the child experiences physical harm (e.g., rash from soiled clothing, frostbite from inappropriate clothing);
- Family is homeless; or
- Caregiver lacks resources or severely mismanages available resources. Caregiver may consistently leave child's basic needs unmet while using resources for other priorities.

Do not select if these conditions exist but do not pose a threat of illness or injury.

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. The condition itself does not necessitate selecting "d."

a. *Preventative health care is practiced*. The caregiver has no current health concerns that affect family functioning. The caregiver proactively seeks preventive health care for themself and the family. The caregiver promotes a healthy lifestyle, including nutrition, physical activity, and recreational activities that promote overall health and well-being.
b. *Health concerns or disabilities do not affect family functioning*. Caregiver may have a medical condition, but they are consistently able to meet the child's needs (e.g., caregiver with mild or well-controlled lupus who is able to participate in most of the child's activities, and child is not experiencing a sense of loss).
c. *Health concerns or disabilities affect family functioning*. The caregiver has health concerns or conditions that affect family functioning and/or family resources; or caregiver may occasionally struggle to meet child's needs because of health limitations (e.g., chronic medical condition, physical disability), and child's needs are sometimes unmet. Caregiver conditions have not resulted in serious harm to child and are not likely to result in serious harm, but the child experiences some adverse impact. Examples of impact on the child include but are not limited to the following.
    - Child may occasionally worry or feel stress about caregiver's health, but such worry does not interfere with their 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; caregiver's lupus makes it impossible for them to participate fully in child's activities, and child feels sad).
    - Child may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.
    - Child's basic needs may sometimes be unmet due to caregiver incapacity, but the child has not experienced injury and is not likely to experience serious harm.

d. *Serious health concerns or disabilities result in inability to care for the child*. The caregiver has one or more health conditions that limit the caregiver's ability to meet the child's needs to the extent that a child has already experienced significant physical or emotional harm or is likely to. Examples of threats of serious harm to the child include but are not limited to the following.

- Child may spend substantial time worrying about the caregiver's health, to the extent that the child is not engaging in play or is struggling in school.
- Child may assume parenting responsibilities for self or siblings in ways that interfere with development or functioning.
- Child may experience intense loss or grief when caregiver is not emotionally or physically available (e.g., repeated caregiver hospitalizations, caregiver so incapacitated that they cannot respond to child).

Caregiver cannot meet child's needs for food, shelter, or supervision (e.g., caregiver has severe lupus and 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 needs).

SN3. Parenting Practices

Parenting practices include knowledge, skills, and abilities demonstrated by the caregiver.

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

a. *Strong skills*. The caregiver displays good knowledge and understanding of age-appropriate parenting skills and integrates this daily, including active participation in the education of the child in the household (monitoring homework completion, participating in school meetings, etc.). The caregiver expresses hope for and recognizes the child's abilities and strengths and encourages participation in family and community events and activities. The caregiver advocates for the family and responds to changing needs. Examples of such parenting include but are not limited to the following.

- Caregiver has the ability to recognize and respond to the child's cues.
- Caregiver has an understanding of age- and developmentally appropriate expectations for the child and promotes and encourages extracurricular or developmental growth activities.
- Caregiver spends quality time with the child and supports the child when the child is upset.

b. *Adequately parents and protects the child*. The caregiver displays adequate parenting skills that are age-appropriate for the child in areas of expectations, discipline, communication, protection, education, attachment, and nurturing. The caregiver has basic knowledge and skills to parent and encourages and meets all children's educational needs. Examples of such parenting include but are not limited to the following.

- When the child 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 the child understand limits and self-regulate behavior (as age-appropriate).
- Child is growing to have a developmentally appropriate sense of behavioral expectations and is learning to manage their behavior well.
- Caregiver provides adequately for child's basic needs.
- Minimally, caregiver periodically spends time with child, supports child when child is upset, and lets child know that they are loved and valued.

c. *Inadequately parents and protects the child*. The caregiver needs improvement in basic parenting skills. The caregiver has some unrealistic expectations and gaps in parenting skills; demonstrates poor knowledge of age-appropriate disciplinary methods; fails to provide attachment; and/or lacks knowledge of child development, which interferes with effective parenting (includes issues regarding sexual development and lack of appropriate sexual boundaries). The caregiver demonstrates an inability to support the child in maintaining adequate school attendance and/or meeting the child's educational needs (whether homeschooling, online, or in person). Examples of such parenting include but are not limited to the following.

- Caregiver seldom sets limits or expectations for the child in advance or sets limits or expectations that are somewhat outside of the range of child's potential; and/or when child errs, caregiver often fails to respond at all or responds by blaming child, calling child names, using physical discipline that does not injure, etc.
- Caregiver frequently fails to meet some of child's basic needs, often because caregiver did not notice or was unaware of the child's need. Child experiences so much worry over basic needs that child is developing symptoms such as lack of concentration, difficulty sleeping, hoarding, or stealing food.
- Caregiver seldom expresses love or value for the child. Child may worry about their place in the life of the caregiver and/or may frequently experience self-doubt. However, child is able to function on a daily basis in developmentally expected ways.

d. *Destructive/abusive parenting*. The caregiver displays destructive or abusive parenting patterns that result in significant harm to the child. The caregiver has not enrolled the child in school or prohibits the child from attending school. (Children who are homeschooled are considered to be enrolled in and attending school.) Examples may include but are not limited to the following.

- Caregiver sexually abused the child or failed to protect the child from sexual abuse.
- Caregiver repeatedly uses severe or excessive discipline that caused or is likely to cause serious injury.
- Caregiver makes use of torture; suffocation; immersion in scalding water; or other unusual, extreme, or cruel discipline.
- Caregiver engages in chronic rejection, hostility, blaming, isolating, terrorizing, or profound inattention to or neglect of the child's physical and emotional needs.
- Caregiver is responsible for chronic, serious neglect that threatens the child's safety and well-being.
- Caregiver is unable or unwilling to protect the child from harm by another.

- Caregiver sets no limits or expectations, or sets limits or expectations that are far beyond the range of child's potential; and when child errs, caregiver intervenes with physical or verbal violence, resulting in serious physical or emotional harm to the child.
- Caregiver has not set limits or expectations for the child, to the extent that the child has no sense of commonly acceptable behavior and no ability to manage their own behavior; child has already or is likely to engage in delinquent behaviors.
- Caregiver is unaware of the child's needs to the extent that the child has become seriously ill or injured due to unmet basic needs.
- Caregiver rarely, if ever, expresses love or value for the child; AND the child is showing signs of emotional harm. Symptoms of emotional harm include but are not limited to: fear of the caregiver, nightmares, aggression toward siblings or peers, anxiety, unusual protective behaviors toward siblings, thumb sucking (and other indicators of developmental regression), and *Diagnostic and Statistical Manual of Mental Disorders* 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.

a. *Strong support system*. The family regularly engages with a strong, mutual support system. Individuals interact with extended family, friends, religious, and/or community supports or services that provide a wide range of resources. The family engages these resources, or resources proactively help the family address problems.
b. *Adequate support system*. As needs arise, the family uses extended family, friendship, religious, and community resources for support and/or services such as childcare, transportation, housing, supervision, parenting and emotional support, and guidance.
c. *Limited support system*. The family has a limited support system, is isolated, or is reluctant to use available support to address one or more identified problems. Supportive persons or resources are unable or unwilling to help the family address problems or concerns. As a result, the child experiences some isolation or unmet needs; however, this has not created a safety threat. This may include the following.
    - A sufficient social support system is lacking.
    - The family is not using the support that is available.

      AND/OR
    - The support provided either contributes to child distress or adversely impairs the caregiver's ability to create long-term safety.

d. *No support system*. The caregiver is unable to resolve conditions that create a safety threat for the child because of limits in the ability of the caregiver's social support system to help in ways that would keep the child safe. This may include the following.
   - No one is able to help provide concrete support that is needed, and this has contributed to a safety threat (e.g., needed medical care for child 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 child's needs, which has resulted in a safety threat (e.g., caregiver cannot get respite care and as a result either leaves child unattended in an unsafe situation or stays with child but loses control and hurts child).
   - Involvement of the social support system directly creates a safety threat for the child (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 or controlling behaviors in this item. Select "b" if the caregiver is the only adult in the household.

The caregiver's relationships with other adult household members:

a. *Actively help create safety, permanency, and child well-being*. Caregiver and other adult household members have and demonstrate healthy interpersonal relationships, including through communication, shared agreements, mutual respect, empathy, and safe conflict resolution.
b. *Are not strengths or needs for safety, permanency, or child well-being*. Caregiver and other household members have relationships that do not adversely affect child, OR there are no adult household members other than caregiver.
c. *Are needs for safety, permanency, or child well-being*. Caregiver and other household members or child's other caregiver experience conflict to the extent that child is aware of and troubled by conflict.

   OR

   Child is confused and/or upset due to how caregiver handles introduction of new intimate partners.
d. *Contribute to imminent risk of serious physical or emotional harm to the child*. Conflict among adult household members is so persistent and severe that child's needs are unmet to the extent that the child has been or is in danger of being seriously harmed.

   OR

   Caregiver allows individuals who are violent or sexual toward the child to be part of the household.

   OR

   Caregiver's relationship with child's other caregivers continues to involve child in conflict to the extent that child is seriously emotionally harmed and/or caused to experience repeated medical or legal examinations due to repeated unfounded allegations against the other caregiver.

SN6. Intimate Partner Violence

Intimate partner violence definition: One person in an intimate relationship, now or in the past, using a pattern of methods to gain and maintain power and control over the other person. This does not include violence between a caregiver and a minor child.

The caregiver's intimate relationships:

a. *Actively help create safety, permanency, and child 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

   This contributes to safety for the child by effectively protecting the child from violence and teaching and demonstrating nonviolence to the child.

   For example, the caregiver may have a history of violent relationships, but they have developed new patterns of behavior and consciously choose relationships that are not violent.

b. *Are not strengths or needs for safety, permanency, or child well-being*. The caregiver is not currently in and has not been in a relationship that includes violence, threats or intimidation, or controlling behavior.

   OR

   The caregiver is or has been in a relationship that includes a minimal degree of violence, threats or intimidation, or controlling behavior; but the child 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 is unaware or reports being unaffected.)

c. *Are needs for safety, permanency, or child well-being*. The caregiver is or has been in a relationship characterized by violence or a pattern of threats/intimidation or controlling behavior, and the child is aware of and troubled by this.

   OR

   The violence, threats or 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 risk of serious physical or emotional harm to the child*. The caregiver is in or has recently left a relationship characterized by severe household violence; and the child has been seriously hurt, physically or emotionally, by the violence.

   OR

   The caregiver remains in a violent relationship because it is the safest choice, and at least one partner is unwilling to recognize and/or address the violence.

SN7. Substance Use

Include alcohol, other illegal drugs, and prescription drugs that are not used according to prescription.

a. *Demonstrates healthy knowledge of and behavior related to alcohol and drugs*. The caregiver may use alcohol or prescribed drugs; however, use does not negatively affect parenting skills and functioning. The caregiver models or demonstrates an understanding of the choices made about use or abstinence and the effects of alcohol and drugs on behavior and society. The caregiver demonstrates a commitment to educating children about the impact of drug and alcohol use. The caregiver stores substances, including edibles and paraphernalia, in a safe location out of reach of children.
b. *Alcohol or prescribed drug use/no use*. The caregiver may have a history of substance use or may currently use alcohol or prescribed drugs; however, use does not negatively affect parenting skills and functioning. The caregiver stores substances, including edibles and paraphernalia, in a safe location out of reach of children. Include abstinence.
c. *Alcohol or drug misuse*. The caregiver continues to use despite negative consequences in some areas, such as family, social, health, legal, or financial problems. The caregiver may need help to achieve and/or maintain abstinence from alcohol or drugs. The caregiver may leave substances, edibles, and/or paraphernalia within reach of children. The caregiver may drive under the influence with children in the vehicle.
d. *Chronic alcohol or drug misuse*. The caregiver's use of alcohol or drugs results in behaviors that impede the ability to meet their own and/or the child's basic needs. The caregiver experiences some degree of impairment in most areas, including family, social, health, legal, and financial problems. The caregiver may need intensive structure and support to achieve abstinence from alcohol or drugs. The caregiver may leave substances, edibles, and/or paraphernalia within reach of children. The caregiver may drive under the influence with children in the vehicle. Children may be exposed to adults who pose a threat to them through heavy impairment, use of weapons, sales of drugs, and/or drug trafficking.

SN8. Mental Health

Mental health includes a diagnosed condition (which is not automatically a need) and also the caregiver's coping skills when behaviors may not rise to the level of diagnosis but nonetheless affect family functioning. For example, severe unmanaged stress may not lead to a mental health diagnosis but may negatively affect the child. Similarly, a caregiver with exceptional coping skills may be able to parent and protect the child 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.

a. *No mental health concerns*. Caregiver does not have a current mental health diagnosis or current symptoms of a mental health condition.

b. *Mental health concerns being managed effectively*. The caregiver has a mental health diagnosis but is effectively managing symptoms such that there is no impact on family functioning. For example, the caregiver has been diagnosed with depression, is taking antidepressants, and can consistently complete necessary tasks despite minor symptoms.

c. *Mild to moderate symptoms*. The caregiver has periodic mental health symptoms, including but not limited to low self-esteem, apathy, or symptoms of depression. These symptoms occasionally impair the caregiver's ability to perform in one or more areas of parental functioning (e.g., occasionally oversleeping and not sending the child to school or preparing meals, or having emotional outbursts).

d. *Chronic/severe symptoms*. The caregiver has chronic, severe mental health symptoms (e.g., depression, apathy, or severely low self-esteem). These symptoms impair the caregiver's ability to perform in one or more areas of parental functioning, employment, education, provision of food and shelter, or maintenance of hygiene or living environment. The above has affected the child's safety or well-being.

SN9. Prior Adverse Experiences/Trauma

Trauma may occur when a person has experienced, witnessed, or been confronted with an event of actual or threatened death or serious injury, a threat of serious physical harm to self or others, or emotional abuse. Trauma may be caused by many experiences, e.g., serious physical harm; sexual abuse; bullying; intimate partner violence; natural disasters; and long-term exposure to extreme poverty, neglect, or verbal abuse.

a. *Experienced at least one traumatic event AND maintained or resumed daily functioning*. The caregiver experienced one or more traumatic events in the past and can function in most daily activities and social relationships. The caregiver uses a variety of positive methods to deal with the traumatic events that occurred.

b. *No known traumatic experiences or symptoms*. The caregiver has no history of traumatic experiences OR has a history of trauma but is not experiencing any symptoms from it, and it does not affect care for the child (either because there is no impact on the caregiver's functioning or because the caregiver has learned to manage the impact on their functioning effectively).

c. *Experienced some trauma and has some symptoms*.

   The caregiver experienced one or more traumatic events in the past AND has current symptoms that reflect some traumatic stress. However, the caregiver is continuing to function in some, but not all, daily activities and social relationships.

d. *Experienced traumatic event and has significant symptoms*. The caregiver experienced one or more traumatic events AND is currently experiencing severe symptoms that may reflect traumatic stress, such as:

   - Suicidal ideation or self-harming behavior;
   - Severe behavioral outbursts;
   - Severe changes in eating or sleeping;
   - Severe withdrawal; OR

- Not functioning in most aspects of daily activities and social relationships.

SN10. Coping Skills

a. *Has strong coping skills and uses them*. Caregiver demonstrates the ability to deal with adversity, crises, and long-term problems in a constructive manner. Demonstrates realistic, logical thinking and judgment. Displays resiliency; has a positive, hopeful attitude. Recognizes impact of crises on the child's emotional health and takes steps to safeguard the child's emotional well-being.

b. *Has adequate coping skills and uses them*. Caregiver demonstrates emotional responses that are consistent with circumstances; displays ability to cope with adversity, crises, or long-term problems adequately while continuing to meet immediate needs of self and children. Caregiver may have a mental health condition, low functioning, or a developmental disability but has demonstrated an ability to cope with stress or crises independently or through accessing appropriate services and support.

c. *Has minimal coping skills and rarely uses them*. Caregiver has occasional difficulty dealing with situational stress, crises, or problems. These impairments negatively affect the caregiver's ability to perform in one or more areas of parental functioning, employment or education, or provision of food and shelter. Limited coping skills may be a result of a mental health condition, low functioning, and/or a developmental disability.

d. *No coping skills*. Caregiver has chronic, severe difficulty dealing with stress, crises, or problems. Caregiver response to stress or crises may cause crises to worsen or lengthen in time or may cause other crises for the household. Impairment in coping skills has severely affected caregiver's ability to perform in one or more areas of parental functioning, employment or education, or provision of food and shelter. Coping skills may be impaired as a result of mental health condition, low functioning, and/or a developmental disability.

SN11. Cognitive/Developmental Abilities

Include diagnosed or suspected cognitive conditions, including developmental disabilities, traumatic brain injury, or dementia or Alzheimer's disease. When assessing, consider both the diagnosed or suspected condition AND the impact that it has on the caregiver's ability to adequately parent and protect the child. The condition itself does not necessitate the selection of "d."

a. *Consistently demonstrates an understanding of complex information and applies information to solve difficult problems*. The caregiver demonstrates broad knowledge and the capacity to understand complex information and uses the information to develop effective (and often creative) solutions to difficult problems related to care of the child, with or without support.

b. *Understands essential information and applies information to problems*. The caregiver demonstrates sufficient capacity to understand essential information; navigate daily challenges; and make decisions on behalf of self, family, and children that support ongoing safety, with or without support.

c. *Some difficulty understanding or applying essential information*. The caregiver is occasionally unable to understand or apply information that is necessary for the family's daily functioning and

caregiving, even with support. For example, the caregiver requires instructions to be broken down into small steps in order to successfully follow them.

d. *Substantial inability to understand or apply essential information*. The caregiver is unable to understand or apply information that is necessary for the child's safety, even with support. For example, despite multiple opportunities for instruction, the caregiver is unable to learn how to feed an infant.

SN12. Other Identified Caregiver Strength or Need (not covered in SN1 – SN11)

Select "not applicable" if the caregiver does not have any strengths or needs that are relevant for family case planning beyond those captured in the areas above.

OR

An additional need or strength has been identified that:

a. *Actively helps create safety, permanency, and child 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 needs for safety, permanency, or child well-being*. A caregiver has an area of strength or need that is not included in other areas, but this area is not relevant for family case planning.
c. *Is a need for safety, permanency, or child 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. The family perceives that they would benefit from services and support that address the need.
d. *Contributes to imminent risk of serious physical or emotional harm to the child*. A caregiver has a need that has a serious impact on family functioning, placing the child at imminent risk of serious harm.

SECTION 2: CHILD STRENGTHS AND NEEDS ASSESSMENT

A. HOUSEHOLD CONTEXT

Systems of shared actions, values, beliefs, and traditions guide the behavior of families and communities. These systems may be related to a family member's personal characteristics, such as race, ethnicity, tribal affiliation, gender, religious/spiritual affiliation, disability, or other social characteristic.

Family members may be affiliated with multiple systems or groups, and what matters most to a person's self-image may shift with different contexts. For example, a child who is disabled may strongly connect to that characteristic in certain situations, while in other situations their religious affiliation may be more relevant.

Connecting Traditions, Values, and Personal Characteristics

Consider how the family's traditions, values, norms, and past or current experiences of discrimination or oppression may influence or shape the child's perspective. In particular, consider:

- How the child sees themself demographically;
- Any past or current experiences that are important or relevant to this child; and
- Any coping skills, strengths, and survival skills this child has developed or demonstrated in facing oppression or discrimination.

How do all of the above influence or shape the child?

The child's perspective on traditions, values, personal characteristics, norms, and past or current experiences:

a. *Helps them create safety, permanency, and well-being for themself*. The child draws upon their traditions and values to respond to challenges in ways that create safety for the child.
b. *Has no effect on their safety, permanency, or well-being*. The child is connected to a community and/or identifies with a community, and this has no impact on their safety.
c. *Makes it difficult for them to experience long-term safety, permanency, or well-being*. The child is connected to a community and/or identifies with a community in ways that cause struggles, such as mild to moderate conflict with the caregiver over traditions or values, or disrupted relationships with the caregiver based on differences.
d. *Contributes to imminent risk of serious physical or emotional harm to the child*. The child is connected to a community and/or identifies with a community in ways that cause danger for the child, such as physically or emotionally harming themself over differences in traditions or values.

B. CHILD AREAS

CSN1. Emotional/Behavioral Health

Note: Read all four options' definitions before making a selection. Some children may require services because their behaviors may be compensatory ones that mask a trauma response.

a. *Strong emotional/behavioral adjustment*. The child displays strong coping skills in dealing with crises and trauma, disappointment, and daily challenges. The child is able to develop and maintain trusting relationships. The child understands and accepts limits and expresses anger, frustration, and sadness in a constructive manner. The child is able to identify the need for, seek, and accept guidance. Developmentally appropriate acting out occurs. The child demonstrates developmentally appropriate emotional regulation.
b. *Adequate emotional/behavioral adjustment*. The child displays developmentally appropriate emotional/coping responses that do not interfere with school, family, or community functioning.

The child may demonstrate some depression, anxiety, or withdrawal symptoms that are situationally related. The child maintains situationally appropriate emotional control. The child is able to understand and accept developmentally appropriate consequences. The child recovers from emotional disruption or stress responses with support.

c. *Limited emotional/behavioral adjustment*. The child has occasional difficulty dealing with situational stress, crises, or problems, which impairs functioning. The child displays periodic mental health symptoms, including but not limited to depression, running away, somatic complaints, hostile behavior, or apathy. The child has multiple episodes of acting out, which may include an inability to accept limits on or consequences for behavior. The child has a pattern of dysfunctional behaviors that limits child or family activities, such as going to movies, eating at restaurants, or playing appropriately with peers. The child experiences periodic emotional disruption that may require caregiver or professional intervention. The opposite may also be true, where the child does not express age-appropriate behavior despite prior trauma (e.g., overachieving, keeping the peace, parentified child).

d. *Severely limited emotional/behavioral adjustment*. The child's ability to perform in one or more areas of functioning is severely impaired due to chronic or severe mental health symptoms, such as setting fires, suicidal behavior, or violent behavior toward people and/or animals. The child has a pattern of dysfunctional behavior that prohibits child or family activities (e.g., going to movies, eating at restaurants, playing appropriately with peers); or there is evidence that behavior is rapidly deteriorating. The child experiences frequent and/or severe mental health symptoms that require a higher level of intervention, including but not limited to one-on-one supervision, crisis intervention, or out-of-home placement.

CSN2. Trauma

Trauma may occur when a person has experienced, witnessed, or been confronted with an event of actual or threatened death or serious injury, or a threat of serious physical harm to self or others. Trauma may be caused by many experiences (e.g., serious physical harm; sexual abuse; bullying; intimate partner violence; natural disasters; long-term exposure to extreme poverty, neglect, or verbal abuse).

a. *The child's response to prior trauma contributes to their safety*. The child has a prior experience of trauma, but that prior trauma provides the child with additional skills to improve daily functioning.

b. *The child has not experienced trauma; OR the child has experienced trauma, but no additional intervention is needed*. The child may or may not have a prior history of trauma; however, any traumatic experiences do not affect care for the child, either because there is no impact on the child's functioning or because the child has learned to manage the impact on their functioning effectively.

c. *The child's response to prior trauma is a concern, AND it is an ongoing unmet need*. The child has experienced trauma; AND the child's response involved fear, helplessness, or worry that sometimes impairs their functioning and sometimes causes distress. Child does not have long-term indicators of permanent harm or distress but could learn to manage the impacts of trauma on their functioning; or they have begun to learn to apply some strategies to manage these responses, and they sometimes use them.

d. *The child's response to prior trauma is a concern that directly contributes to danger to the child*. The child has experienced trauma; AND the child's response involved intense fear, helplessness, or panic, causing impaired functioning and significant distress or harm to the child. For example, the child has not accessed services, cannot use coping strategies, and/or has not received intervention to help manage their responses; AND this has resulted in significant harm to the child. The child may deny the traumatic experience or how it is affecting them.

CSN3. Child Development

a. *Advanced development*. The child's physical and cognitive skills are above expectations for their chronological age.
b. *Age-appropriate development*. The child's physical and cognitive skills are consistent with their chronological age.
c. *Limited development*. The child does not exhibit most physical and cognitive skills expected for their chronological age.
d. *Severely limited development*. Most of the child's physical and cognitive skills are two or more developmental levels behind chronological age expectations.

CSN4. Education

a. *Outstanding academic achievement*. The child is performing above grade level and/or is exceeding the expectations of the specific educational plan.
b. *Satisfactory academic achievement OR the child is not of school age*. The child is performing at grade level and/or is meeting the expectations of the specific educational plan, or the child is not of school age.
c. *Academic difficulty*. The child is performing below grade level in at least one, but not more than half, of their academic subject areas; and/or the child is struggling to meet the goals of the existing educational plan. The existing educational plan may need modification.
d. *Severe academic difficulty*. The child is performing below grade level in more than half of their academic subject areas, and/or the child is not meeting the goals of the existing educational plan. The existing educational plan needs modification, if applicable.

CSN5. Social Relationships

When considering adult relationships, consider the child's relationships with adults who are not immediate family members or resource family members. This area 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's relationships with other children in school and the community. Exclude relationships with siblings.

a. *Strong social relationships*. The child enjoys and participates in a variety of constructive, age-appropriate social activities. The child enjoys reciprocal, positive relationships with others. The child can seek out and maintain healthy relationships, even through conflict.
b. *Adequate social relationships*. The child demonstrates adequate social skills and maintains stable relationships with others. Occasional conflicts are minor and easily resolved.
c. *Limited social relationships*. The child demonstrates inconsistent social skills and has limited positive interactions with others. Conflicts are more frequent and serious, and the child may be unable to resolve them.
d. *Poor social relationships*. The child has poor social skills, as demonstrated by frequent conflictual relationships; or most interactions are negative or exploitative; or the child is isolated and lacks a support system.

CSN6. Physical Health

Physical health means physical well-being, which includes dental and vision care. Also indicate whether the child's immunizations are current. When rating this section, please keep in mind the family's beliefs and how they may influence treatment choices.

a. *No health care needs or disabilities*. The child demonstrates good health and hygiene care, involving awareness of nutrition and exercise. The child receives routine preventive and medical/dental/vision care and/or immunization.
b. *Minor health problems or disabilities that are being addressed with minimal intervention and/or medication*. The child has adequate health. Minimal interventions are those that typically require no formal training (e.g., oral medications).
c. *Health care needs or disabilities that require routine interventions*. The child has minor health/disability needs. Routine interventions are those that are typically provided by laypersons after minimal instruction (e.g., glucose testing and insulin, or cast care).
d. *Serious health/disability needs that require ongoing treatment and interventions by professionals or trained caregivers AND/OR has a current unmet medical need*. Those who provide treatment/interventions have received substantial instruction (e.g., central line feeding, paraplegic care, or wound dressing changes).

CSN7. 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. *Actively chooses an alcohol- and drug-free lifestyle*. The child does not use alcohol or other drugs and is aware of consequences of use. The child avoids peer relations and social activities involving alcohol and other drugs and/or chooses not to use substances despite peer pressure or opportunities to do so.

b. *No use or some use*. The child does not use alcohol or other drugs. The child may have tried or occasionally used alcohol or other drugs, but there is no indication of sustained use or of uses that cause disruptive behavior or discord in school, community, family, and/or work relationships.

c. *Alcohol or other drug use*. The child's alcohol or other drug use results in disruptive behavior and discord in school, community, family, and work relationships. Use may have broadened to include multiple drugs.

d. *Chronic alcohol or other drug use*. The child's chronic alcohol or other drug use results in severe disruption of functioning, such as loss of relationships or job; school suspension, expulsion, or drop out; problems with the law; and/or physical harm to self or others. The child may require medical intervention to detoxify.

CSN8. Delinquent Behavior

Delinquent behavior includes any action that would constitute a crime. Consider this area to include both offenses for which the child has been arrested or charged and those that have not yet come to the attention of law enforcement.

a. *No delinquent behavior*. The child is involved in community service and/or crime prevention programs and takes a stance against crime; and/or the child has no arrest history, and there is no other indication of criminal behavior.

b. *No current or recent delinquent behavior*. The child has an arrest history, but there is no current indication of criminal behavior; or the child has successfully completed probation, and there has been no criminal behavior **in the past two years**.

c. *Occasional delinquent behavior*. The child is engaging in or has engaged in occasional, nonviolent delinquent behavior and may have been arrested, been placed on probation, or had probation violations.

d. *Significant delinquent behavior*. The child is or has been involved in any violent and/or repeated nonviolent delinquent behavior that has or could have resulted in consequences such as arrests, incarcerations, or probation violations. "Violent behavior" includes aggressive behavior in any form that has resulted or is likely to result in an injury to another person.

CSN9. Family of Origin Relationships

For children in voluntary or court-ordered placement, answer for the child's family of origin, not their placement family.

a. *Nurturing/supportive relationships*. The child experiences positive interactions with family members and has a sense of belonging within the family. The family defines roles, has clear boundaries, and supports the child's growth and development.

b. *Adequate relationships*. The child experiences positive interactions with family members and feels safe and secure in the family, despite some unresolved family conflicts.

c. *Strained relationships*. Stress or discord within the family interferes with the child's sense of safety and security. The family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own.
d. *Harmful relationships*. Chronic family stress, conflict, or violence severely interferes with the child'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.

CSN10. Relationship With Substitute Care Provider (if child is in care)

Consider the child's wishes and feelings as appropriate. Indicate whether those wishes and feelings assist in the development of strengths or create struggles for the child.

When assessing this item, keep in mind that the child may have different relationships with adults and with children in the home or facility. Please consider both when documenting strengths and struggles.

Not applicable; child is not in care.

a. *Strong relationships with substitute care provider*. The child has developed a nurturing and supportive relationship with at least one substitute care provider. There is positive interaction and attachment between the child and caregiver or others in the caregiver's household or the facility; the child is supported and has a sense of belonging.
b. *Adequate relationships with substitute care provider*. The child has adequate relationships with at least one substitute care provider. Interactions between the child and substitute care provider (and others in the caregiver's household or the facility) are generally positive; age-appropriate attachments exist despite some problems.
c. *Limited relationships with substitute care provider*. The child has some conflicts with at least one substitute care provider that have resulted or could result in the child feeling unsafe or unaccepted in the placement; however, with support, these issues can be mitigated. Problems limit positive interactions and appropriate attachments with one or more people in the substitute care provider's household or the facility.
d. *Serious conflicts with substitute care provider*. The child has serious problems or conflicts with one or more members of the substitute care provider's household or the facility. Chronic problems severely interfere with the child's interactions and attachments with one or more members of the substitute care provider's household or the facility.

CSN11. Transitional Youth Services (if age 14 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;
- Completing daily activities (e.g., hygiene, laundry, housekeeping, grocery shopping, cooking, basic health care);
- Drivers education and identification; and
- Supportive adult and peer connections.

Not applicable

Child is not in out-of-home care.

a. *Prepared to function as an adult*. The child has demonstrated and practiced skills necessary for independent living and is prepared to be self-sufficient.
b. *Making progress toward being prepared for adulthood*. The child has had an opportunity to demonstrate and/or practice the skills necessary for independent living. The child is making progress even though they may be aware that they are not fully prepared. Child is participating in formal or informal independent living services.
c. *Attempting to prepare for adulthood but lacks the confidence, emotional maturity, and/or sufficient skills to live independently*. The child may have developed only some or none of the skills necessary for independent living. The child believes they can live independently, but they lack the skills or ability to do so.
d. *Not prepared or is refusing to prepare for adulthood*. The child is not actively participating in activities to prepare for adulthood or is unable to prepare in key areas that may include but are not limited to the following.
    - Child is in an out-of-state treatment facility or mental health facility or is incarcerated, and independent living skills development is limited.
    - Child has developmental delays that limit independent living.

For child age 14 or older, select all that apply to preparation for adulthood.

- Youth has been referred to a Transitional Youth Services Coordinator (ages 14 and older).
- Youth has received and signed Youth Acknowledgement of Rights in Foster Care, and the rights contained in the Youth Rights in Foster Care—The Short List and Be Your Own Advocate documents have been explained to the youth in an age-appropriate way (ages 14 and older).
- A Transitional Team has been developed (ages 14 and older).
- A Life Plan has been completed (ages 14 and older).
- The life skills assessment has been completed (ages 14 and older).
- The youth has been invited to attend life skills classes (ages 14 and older).

- Youth has been informed that they have the right to participate in the extended foster care program after reaching age 18 and until the age of 21 (or any other age as may be required under federal law) (ages 14 and older).
- If youth is planning to exit care, a final Transitional Team meeting has been held 90 or more days prior to the planned exit date (ages 17 and older).
- For youth age 18 or older, an extended foster care budget has been completed (ages 18 and older).
- Youth is participating in the extended foster care program (ages 18 and older).

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

a. *Actively helps them create safety, permanency, and well-being for themself*. A child 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 need for their safety, permanency, or well-being*. A child has an area of strength or need that is not included in other areas, but this area is not relevant for family case planning.
c. *Is a need for their safety, permanency, or well-being*. A child has a need that has a moderate impact on family functioning. The family perceives that the family would benefit from services and support that address the need.
d. *Contributes to imminent risk of serious physical or emotional harm to the child*. A child has a serious need that has a significant impact on family functioning.

PROCEDURES

The family case plan tool is used to evaluate the presenting strengths and needs 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 family case plan. This tool is used to systematically identify critical family needs that underlie safety in the family and conditions related to worries about possible future harm, and it helps with planning effective interventions with the family. The family case plan tool serves several purposes.

- It ensures that all workers consistently consider each family's strengths and needs in an objective format when assessing the need for interventions that aim to improve child outcomes.
- It provides a guide to support collaborative assessment for development of family 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 safety.
- The initial family case plan tool, when followed by periodic reassessments, permits family members, workers, and their supervisors to assess changes in family functioning together and thus assess the effects of their work together over time during the family case plan service period.
- In the aggregate, family case plan tool 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.

The child assessment portion is completed for each child in the household and for whom a case is established in the Division information management system.

WHO

The primary Family Services Worker (FSW) who is assigned to the case.

WHEN

- **Initial:** Prior to the initial family case plan, which is due within 30 days of case opening.
- **Review:** Every 90 days to inform the family case plan update.

DECISION

Identifies the priority needs of caregivers and all needs of children that must be addressed in the family case plan. Goals, objectives, and interventions in a family case plan should relate to one or more of the priority needs.

Identifies a family's priority strengths, which should be incorporated into the family case plan to the greatest extent possible, as a means to address identified needs.

APPROPRIATE COMPLETION

Section 1 contains several demographic questions that are important in informing both empathetic and nonjudgmental practice and data collection for evaluation purposes. Do your best to engage caregivers and children to gather the most accurate demographic information. Remember, "unasked" is different from "unknown." Directly ask each question that you do not already have answers to at this stage, and verify any information that may have been entered based on assumptions. Reference Appendix A for further guidance on preparing for and engaging in conversations with families about their individual and community context.

Familiarize yourself with all questions on the tool, including the 12 caregiver areas and the 12 child areas of the family case plan tool and the corresponding definitions. You will notice that the areas are ones that you began to look at in the assessments prior to the family case plan tool, with the difference that the responses to these items lead to specific family case planning goals and objectives.

Once you are familiar with the areas that must be assessed to complete the family case plan tool, conduct your family assessment as you normally would, using good safety-organized practice to collect information from the child, caregiver, and/or collateral sources.

Each of the areas in the assessment represents a significant area of family functioning that may support or impede a family's ability to maintain children's safety, permanency, and well-being. There may be some overlap or interaction between areas (e.g., a need in the area 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 area as it relates to their ability to effectively provide for the child's safety.

For each area, there are four possible responses.

a. This is a strength response where the behavior actively helps create safety, permanency, and child well-being.
b. This is an "average" or adequate functioning response. It is not a strength or need for safety, permanency, or child well-being. This response is also used for children who are too young to assess in some categories. A caregiver or 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 potential strengths, with the exception of children who are a "b" in some categories because they are too young to assess. For example, an infant may be a "b" for delinquency because they are too young to be assessed in this area, but this should not be selected as a strength for family-planning purposes.

c. This is a need for safety, permanency, or child well-being but does not actively contribute to an SDM safety threat.

d. This is an area that actively contributes to an SDM safety threat.

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 DWIs in the last year; mother states she believes he is an alcoholic; a court-ordered substance use assessment suggests alcohol dependency; father's brother states father has no problem with alcohol). Make a determination based on the assessment skills you have, taking into account the merits of each perspective. The household is assessed by completing all areas. If there are two caregivers, each is assessed and given a score separately.

SN1 TO SN10 AND CSN1 TO CSN12

Determine the appropriate response for each area and select that answer. Note the following.

- CSN1 to CSN10 relate to children in the household.
- CSN10 is answered only for a child in placement and addresses the child's relationship to their substitute care provider.
- CSN11 addresses transitional living issues and is answered only for a young person who is in care and is at least 14 years old.
- SN10 and CSN12 are used when a caregiver or child, respectively, has a unique strength or need that contributes to imminent risk that is not covered in other areas and is relevant to family case planning. If an individual has a strength, select "a." If an individual has an area of strength or need that is not covered in other areas but is not relevant for family case planning, select "b." If an individual has a need, select "c" or "d," depending on the severity of the need. Use the comment box to briefly describe the rating chosen.

PRIORITY NEEDS AND STRENGTHS FOR CAREGIVERS AND CHILDREN

To identify priority strengths and needs for caregivers, consider ratings for areas SN1 through SN11 in Section 1 (caregiver strengths and needs assessment) of the family case plan tool. All identified child needs must be considered in the family case plan.

All areas identified as "d" (contributes to imminent risk of serious physical or emotional harm to the child) should be captured in a worry statement about them and be addressed by both an immediate safety plan and the family case plan. These are priorities to address before the case can be closed.

All items entered as "c" (a need for safety, permanency, or child well-being) should be strongly considered for the family 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 areas identified as "d" and "c."

For needs, enter the area number and name for all areas assessed as a contributor to imminent risk ("d") first and then all areas assessed as a need ("c"). An area may be a priority need for one or both caregivers. Identify whether the assessment of each area is for the primary caregiver, secondary caregiver, or both (P, S, or B).

For priority strengths, enter the area number and title of all areas with an assessment of "a" (actively helps create safety, permanency, and child well-being). Only items with an "a" may be identified as priority strengths. Look at both caregivers to identify strengths. An area may be a priority strength for one or both caregivers. Select "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.

Note: An area may be a priority need for one caregiver and a priority strength for another.

FAMILY CASE PLAN

Write the family case plan 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 should also 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 family case plan tool 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 specific interpretations of appearances and must engage the family in respectful ways to make an accurate assessment. Where it is difficult to distinguish among responses, additional assessment (e.g., psychological, developmental, substance use assessments) may be helpful, particularly if the difference between one rating and another is likely to affect the selection of priority needs.

The family case plan tool identifies priority *areas* to address in the family 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 use and willingness to change in these areas should be considered. Family case plan goals should be behaviorally specific and measurable. If there was an immediate safety plan in place, any continuing safety intervention requirements should now be incorporated into the family case plan.

Once completed, the initial assessment and the resulting family case plan can be used as a foundation for ongoing conversations and monthly assessment between the workers and family members about progress in identified areas of need and use of identified strengths and resources to increase child 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 family case plan will also include information regarding family time. While the SDM system does not guide the decision concerning family time in the initial family case plan, the worker is encouraged to consider the safety threats that led to removal, the risk level, and the specific needs of caregiver and child.

PHYSICAL AND COGNITIVE DEVELOPMENTAL MILESTONES		
AGE	**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.

PHYSICAL AND COGNITIVE DEVELOPMENTAL MILESTONES		
AGE	**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. 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?"

PHYSICAL AND COGNITIVE DEVELOPMENTAL MILESTONES		
AGE	**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.
18 to 21 Years	Physical maturity and reproductive growth leveling off and ending. Understanding of one's own needs and goals in platonic and intimate relationships. Firmer sense of sexual identity.	During late young adulthood, abstract thought is established, judgment continues to develop; able to understand, plan and pursue long range goals. Philosophical and idealistic. Increased concern for the future. Greater capacity to use insight and seek advice from adults.

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.

CONTACT FREQUENCY GUIDELINES

ONGOING WORKER MINIMUM CONTACT FREQUENCY GUIDELINES FOR IN-HOME SERVICES		
RISK LEVEL	**CAREGIVER AND CHILD CONTACTS**	**LOCATION**
Any risk level for children in care for first month	One face-to-face contact per **week** with caregiver One collateral contact	**Must** be in caregiver's residence
Low	**One** face-to-face contact per month with caregiver and child Plus weekly phone or virtual contact **One** collateral contact	**Must** be in caregiver's residence
Moderate	**Two** face-to-face contacts per month with caregiver and child Plus weekly phone or virtual contact **Two** collateral contacts	**One** must be in caregiver's residence
High	**Three** face-to-face contacts per month with caregiver and child Plus weekly phone or virtual contact **Three** collateral contacts	**One** must be in caregiver's residence
Very High	**Four** face-to-face contacts per month with caregiver and child Plus weekly phone or virtual contact **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 aides or approved safety network members. 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

Assess for:

- Any change in safety (vulnerability, safety threats, protective capacity, interventions)
- Progress toward family case plan goals:
  - » Participation in services
  - » Demonstration of skills
- Change in needs (identification of new needs, needs reduction)

CONTACT FREQUENCY GUIDELINES FOR OUT-OF-HOME CASES	
RISK LEVEL	**DOCUMENTED CONTACTS WITH CAREGIVER**
Any risk level for children in care for first month	One face-to-face contact per **week** with caregiver Plus weekly phone or virtual contact One collateral contact
Low	**One** face-to-face contact per month with caregiver Plus weekly phone or virtual contact One collateral contact
Moderate	**Two** face-to-face contacts per month with caregiver Plus weekly phone or virtual contact Two collateral contacts
High	**Three** face-to-face contacts per month with caregiver Plus weekly phone or virtual contact Three collateral contacts
Very High	**Three** face-to-face contacts per month with caregiver Plus weekly phone or virtual contact Three collateral contacts
All Risk Levels Require Documented Contacts With Children	At least one face-to-face contact per week with each child
Additional Considerations	
"Contact" definition	During the course of a month, each caregiver and each child shall be contacted at least once.

CONTACT FREQUENCY GUIDELINES FOR OUT-OF-HOME CASES	
RISK LEVEL	**DOCUMENTED CONTACTS WITH CAREGIVER**
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 family case plan or other agency staff or approved safety network members.
Overrides	A discretionary override to these contact frequency guidelines is permitted based on unique case circumstances that the ongoing worker documents the supervisor approves. All case contacts must at least meet Arkansas Division of Children and Family Services (DCFS) policy requirements.

CONTACT CONTENT

- Assess for any change in safety (vulnerability, safety threats, protective capacity, interventions).
- Progress toward family case plan goals:
  - » Participation in services
  - » Demonstration of skills
- Change in needs (identification of new needs/needs reduction).
- Family time quality.

SDM RISK REASSESSMENT

Family Name: _____ **Case #:** _____

Assessment Date: _____ **Worker Name:** _____

Primary Caregiver Name: _____

Is there a secondary caregiver? ○ Yes ○ No **Secondary Caregiver Name:** _____

Score the first four items 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, score these the same as on the initial risk assessment.

R1. Prior investigations **Score**

○ a. None 0
○ b. One or two 1
○ c. Three or more ..... 2 _____

R2. Household previously received ongoing child protection services

○ a. No 0
○ b. Yes ..... 1 _____

R3. Primary caregiver has a history of abuse or neglect as a child

○ a. No 0
○ b. Yes ..... 1 _____

R4. Current or historical characteristics of children in the household

○ a. Not applicable 0
○ b. One or more present (*select 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 OR REASSESSMENT.

Score

R5. New investigation of abuse or neglect since the initial risk assessment or the last reassessment

- ○ a. No 0
- ○ b. Yes ..... 2 _____

R6. Primary or secondary caregiver alcohol and/or drug misuse since the last assessment or reassessment

Score based on the caregiver demonstrating the least progress.

P S

- ○ ○ a. No history of alcohol or drug misuse 0
- ○ ○ b. No current alcohol or drug misuse; no intervention needed 0
- ○ ○ c. Yes, alcohol or drug misuse; problem is being addressed 0
- ○ ○ d. Yes, alcohol or drug misuse; problem is *not* being addressed ..... 1 _____

R7. Adult relationships in the home

- ○ a. None applicable 0
- ○ b. Yes (*select all that apply*) ..... 1 _____
  - ☐ Harmful or tumultuous relationships
  - ☐ Intimate partner violence

R8. Primary caregiver mental health since the last assessment or reassessment

- ○ 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 *not* being addressed ..... 1 _____

Score

R9. Primary caregiver provides physical care of the child that:

○ a. Meets the child's needs 0

○ b. Does not meet the child's needs ..... 1 _____

R10. Caregiver's progress with family case plan goals (as indicated by behavioral change)

Score based on the caregiver demonstrating the least progress.

P S

○ ○ a. Demonstrates protective behaviors consistent with all family case plan goals and is actively engaged to maintain goals 0

○ ○ b. Demonstrates some protective behaviors consistent with family case plan goals and is actively engaged in activities to achieve goals 0

○ ○ c. Minimally demonstrates protective behaviors consistent with family case plan goals and/or is inconsistently engaged in achieving the goals specified in the family case plan 0

○ ○ d. Does not demonstrate protective behaviors consistent with family case plan goals 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

Select *yes* if a condition applies in the current review period. If *any* condition applies, override final risk level to "very high."

○ Yes ○ No 1. Sexual abuse case AND the offender is likely to have access to the child.

○ Yes ○ No 2. Non-accidental injury to a child under age 3.

○ 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, select "Yes," select 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 (select one): ○ Low ○ Moderate ○ High ○ Very High

Discretionary override reason: _____

☐ Supervisor's discretionary override approval Date: _____

FINAL RISK LEVEL

○ Low ○ Moderate ○ High ○ Very High

RECOMMENDED DECISION

FINAL RISK LEVEL	RECOMMENDATION
Low	Close unless unresolved safety threats remain
Moderate	Close unless unresolved safety threats remain
High	Continue services
Very High	Continue services

PLANNED ACTION

○ Continue services

○ Close **Note: A closing safety assessment is required.**

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

☐ Supervisor's approval of change in planned action Date: _____

DEFINITIONS

R1. Prior investigations

Identify the number of prior child protection investigations (regardless of determination or jurisdiction) involving any current adult household members who were alleged offenders.

Do not count:

- Referrals that were screened out for child protection investigations;
- Investigations where all allegations were on an out-of-home offender (e.g., daycare, substitute care provider) when there is no failure-to-protect allegation against the in-home primary caregiver;
- Investigations in which all alleged offenders are no longer part of the household; or
- Known false reports or administrative closures (if any doubt that it was false, then include it).

a. Select if there were no prior assigned investigations.
b. Select if there were one or two prior assigned investigations.
c. Select if there were three or more prior assigned investigations.

R2. Household previously received ongoing child protection services

Select "Yes" if any adult household members with caregiving responsibilities received or are currently receiving ongoing child protective services (CPS) as a result of a prior child maltreatment investigation or were transferred from Differential Response. Ongoing CPS means in-home and out-of-home services provided by DCFS.

a. Select if the household has not had a prior open CPS case.
b. Select if the household has one or more prior open CPS case.

R3. Primary caregiver has a history of abuse or neglect as a child

The primary caregiver was maltreated as a child. Consider any maltreatment history known to the agency and/or credible statements by the primary caregiver or others. Include situations that would be considered abuse or neglect using current standards, even if the situation was not considered abuse or neglect at the time.

a. Select if the primary caregiver was not maltreated as a child.
b. Select if the primary caregiver was maltreated as a child.

R4. Current or historical characteristics of children in the household

Assess each child in the household and determine the presence of any characteristics below. Select all that apply.

a. Select if no child in the household exhibits characteristics listed below.
b. Select if any child in the household exhibits characteristics listed below, and select all types present.
    - *Developmental disability*. A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include but are not limited to cognitive disabilities, autism spectrum disorder, 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. Examples include but are not limited to dyslexia, dysgraphia, dyspraxia, or auditory or visual processing disorders.
    - *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*. Any child in the household is medically fragile, defined as having a long-term (expected to last six months or more) physical condition requiring medical intervention; or has a diagnosis of malnourishment or failure to thrive.

THE FOLLOWING CASE OBSERVATIONS PERTAIN TO THE PERIOD SINCE THE LAST ASSESSMENT OR 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 conclusion, that have been initiated since the initial assessment or last reassessment. Do not include duplicate referrals.

R6. Primary or secondary caregiver alcohol and/or drug misuse since the last assessment or reassessment

Identify alcohol and drug use by any caregiver during the review period; whether there is a current problem that interferes with caregiver functioning or family functioning; and, if so, how the caregiver 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 misuse problem, rate the more negative behavior of the two caregivers.

Not addressing the problem since the last assessment or 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 or reassessment for driving under the influence or refusing breathalyzer testing;
- Multiple positive urine samples;
- Medical problems resulting from substance use and/or misuse; 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, or a child in the home having a positive toxicology screen as a result of exposure.

a. Select if there is no history of alcohol or drug misuse.
b. Select if there is a history of alcohol or drug misuse that is not current and did not require intervention during the review period.
c. Select if there is alcohol or drug misuse, and the problem is being addressed.
d. Select if there is alcohol or drug misuse, and the problem is *not* being addressed.

R7. Adult relationships in the home

Identify the current status of adult relationships in the household.

a. Select if not applicable or there are no problems observed.
b. Select if there are harmful or tumultuous adult relationships and/or intimate partner violence.
    - *Harmful or 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 intimate partner 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.
    - *Intimate partner violence*. The household has had, since the most recent assessment, a pattern of physical assault/coercive control or periods of intimidation, threats, or harassment by an adult in the household toward their spouse or significant other.

R8. Primary caregiver mental health since the last assessment or reassessment

Determine the primary caregiver's current mental health status. Does the caregiver have a current diagnosis of a significant mental health condition that affects daily functioning, as determined by a mental health clinician (or in some cases without diagnosis if there is enough credible evidence that a mental health condition is present and affected family functioning); and if so, is the condition being addressed?

Not addressing the condition 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 their ability to provide protection, supervision, and care for the child;
- Had referrals for mental health or psychological evaluations; or
- Was recommended for treatment or hospitalization or was treated or hospitalized for a mental health condition.

a. Select if the primary caregiver does not have a current or past mental health condition that interferes with family functioning.
b. Select if the primary caregiver has been diagnosed with a mental health condition but has been symptom-free for at least 12 months and does not require formal treatment. Caregiver may still participate in support groups or use maintenance doses of psychotropic medication.
c. Select if there is a mental health condition that interferes with family functioning and the caregiver is actively engaged in treatment.
d. Select if there is a mental health condition that interferes with family functioning and the problem is *not* being addressed.

R9. Primary caregiver provides physical care of the child that:

Assess whether during this assessment period, the caregiver has provided age-appropriate physical care for all children in the household. Examples may include the following.

- Providing routine and preventative medical and dental care.
- Obtaining medical care for a severe or chronic illness.
- Providing the child with adequate food.
- Providing the child with adequately clean and weather-appropriate clothing.
- Providing safe and adequate housing free of infestations.
- Ensuring poisonous substances (including medications) or dangerous objects are not within reach of a small child.
- Ensuring age-/developmentally appropriate hygiene (e.g., bathing, brushing teeth, changing diapers).

a. Select if physical care meets the child's needs.
b. Select if physical care does not meet the child's needs.

R10. Caregiver's progress with family case plan goals (as indicated by behavioral change)

Compliance with and attendance of services is not sufficient to indicate behavioral change.

Identify whether a caregiver is actively engaged in achieving the family case plan goals specified in the family case plan and is demonstrating skills and behaviors that will enable the caregiver to create and maintain safety for the child (e.g., ability to manage substance use/misuse; 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).

"Family case plan goal" specifically refers to the services in the family 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 participation and progress.

a. *Demonstrates protective behaviors consistent with all family case plan goals and is actively engaged to maintain goals*. Select if the caregiver is regularly demonstrating all behavioral changes identified in the family case plan goals and is able to create long-term safety for children in the household. The caregiver is actively engaged in activities to maintain the goals.
b. *Demonstrates some protective behaviors consistent with family case plan goals and is actively engaged in activities to achieve goals*. Select if the caregiver is demonstrating some new skills and behavioral change consistent with family case plan goals and is actively engaged in achieving the goals but is not regularly demonstrating the behaviors necessary to create long-term safety in all areas.
c. *Minimally demonstrates protective behaviors consistent with family case plan goals and/or is inconsistently engaged in achieving the goals specified in the family case plan*. Select if the caregiver is demonstrating minor behavioral change consistent with family case plan goals but has made little progress toward changing their behavior and is not actively engaged in achieving the goals. Caregiver behavior continues to make it difficult to create safety or may contribute to immediate danger of serious harm.
d. *Does not demonstrate protective behaviors consistent with family case plan goals and/or refuses engagement*. Select if the caregiver has not demonstrated behavioral change consistent with family case plan goals. The caregiver refuses services, sporadically follows the family case plan, or has not demonstrated the necessary skills or behaviors due to a failure or inability to participate. The caregiver is unable to create or maintain safety, or their 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 offender 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 offender is likely to have unmanaged access.
2. *Non-accidental injury to a child under age 3*. Any child under age 3 in the household has any kind of physical injury resulting from a caregiver's actions or inactions.
3. *Severe non-accidental injury*. Any child in the household has a serious physical injury resulting from a caregiver's action or inaction. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn, scald, or severe cut; AND the child requires medical treatment.
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 the caregiver's actions or inactions. 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. The reason a worker may now decrease the risk level is that after a minimum of six months, the worker has acquired significant knowledge about the household. If the worker applies a discretionary override, the reason should be specified, and the final risk level should be selected.

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 caregiver have changed as a result of the family case plan.

The risk reassessment combines items from the initial risk assessment with additional items that evaluate a family's progress toward family case plan goals.

Research has demonstrated that for the reassessment, a single index best categorizes risk for future child protective system involvement. Unlike the initial risk assessment, which contains separate indices for risk of system involvement related to neglect and related to abuse, the risk reassessment comprises 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 primary FSW who is assigned to the case.

WHEN

Prior to each required review, which occurs at least once every 90 days, and any recommendation to close the case or keep it open. To ensure that current SDM assessments are available, they should be completed:

- No more than 30 calendar days prior to completing each family case plan; and
- No more than 30 calendar days prior to recommending case closure.

ALL CASES

Should be completed sooner if there are new circumstances or new information that would affect safety or risk level (e.g., network is providing enhanced safety, caregiver received treatment and is actively demonstrating actions of protection).

DECISION

The risk reassessment helps guide the decision of whether to keep ongoing services open or to close the case based on the family's assessed risk level and consideration of safety threats. The risk reassessment classifies a family's likelihood of future involvement with child protection after receiving ongoing services. The recommended action is based on the final risk classification and professional judgment as supported by policy and practice, including the reassessment of household safety. The worker should discuss the outcome and recommendation with their supervisor. If the action taken differs from the recommendation, the worker must provide brief rationale.

RISK-BASED CASE OPEN/CLOSE GUIDE	
FINAL RISK LEVEL	**RECOMMENDATION**
Low	Close unless unresolved safety threats remain
Moderate	Close unless unresolved safety threats remain
High	Continue services
Very High	Continue services

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 section of this manual.

APPROPRIATE COMPLETION

SCORING INDIVIDUAL ITEMS

Familiarize yourself with the items that are included on the risk reassessment and the accompanying definitions for those items. Each item's score is derived from your observation of the characteristics it describes during interviews with household members (child, caregivers, and others) and collaterals; referrals and case records; or other reliable sources concerning progress in demonstrating behavioral change and meeting family case plan goals. Some characteristics are objective, such as prior child abuse/neglect history or the child's age. Others require you to use judgment based on your 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.

Items R1 – R4: Score the first four items based on conditions that were present at the time of the referral that resulted in the case opening 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.

- **R1** will be scored the same as **Item 4** (Prior investigations . . .) on the initial risk assessment unless new information has become available about conditions that existed at time of the initial risk assessment.
- **R2** will be scored the same as **Item 6** (Household previously received . . .) on the initial risk assessment unless new information has become available about conditions that existed at time of the initial risk assessment.
- **R3** will be scored the same as **Item 8** (Primary caregiver's history. . .) on the initial risk assessment unless new information has become available about conditions that existed at time of the initial risk assessment.
- **R4** will be scored the same as **Item 7** (Current or historical characteristics . . .) on the initial risk assessment unless new information has become available about conditions that existed at time of the initial risk assessment.

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 tool.

OVERRIDE

Consider both policy and discretionary overrides. If any apply, determine the final risk level. If none apply, the scored and final risk level are the same.

Policy Overrides

As with 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, select "yes" for each reason for the override and select "very high" for the final risk level. Policy overrides require supervisory review.

Discretionary Override

A discretionary override is used whenever facts indicate that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment, in which a worker could only *increase* the risk level, the risk reassessment permits you to increase or *decrease* the risk level by one. The reason you may now decrease the risk level is that after a minimum of six months, you have acquired significant knowledge of the family. If a discretionary override applies, select "yes," indicate the reason, and select the override risk level. Discretionary overrides require supervisory approval. You then indicate the final risk level.

DISPOSITION

The agency database 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. Supervisory approval is required for not following the recommended action.

Examples of explanations include the following.

- Continuing a low- or moderate-risk case: *Unresolved safety threats*. Based on the SDM safety assessment, one or more safety threats could not be resolved.
- Closing a high- or very high-risk case:
  - » *Family declined supportive services AND no petition filed*. Family was informed of their high or very high risk level and was encouraged to continue voluntary services. The family declined, *and* no petition will be filed. Select this item even if family does accept any non-DCFS services or other agencies' 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 you will assist the family in making connections to community services. (You 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 case plan tool or other means to identify factors that contribute to risk.

PRACTICE CONSIDERATIONS

You should explain to the family, at the start of the service period, the structure and process for conducting the reassessment; and you should link the reassessment process to the developed family case plan.

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 family case plan or engage in planning for case closure, is highly recommended.

SDM REUNIFICATION ASSESSMENT

ARKANSAS DIVISION OF CHILDREN AND FAMILY SERVICES

Complete for each household to which a child may be returned (e.g., father's home, mother's home).

Family Name: _____ **Case ID#:** _____

Assessment/Reassessment Date: _____ **Household Assessed:** _____

Removal Household? ○ Yes ○ No

Assessment/Reassessment # (1–10): _____

Is there a secondary caregiver? ○ Yes ○ No **Secondary Caregiver Name:**_____

Full name of each child assessed: _____

SECTION 1. REUNIFICATION SAFETY ASSESSMENT

A. SAFETY THREATS

1. **Are any safety threats (identified on the safety assessment) that resulted in the removal still present?**
   - ○ No. Describe below how the initial safety threats were resolved after the child's removal, including a description of caregiver's protective actions.
   - ○ Yes. Describe safety threats (using caregiver, behavior, and impact on child) as they currently exist.

1a. If yes, are caregivers demonstrating protective actions that mitigate the safety threats?

- ○ No. Caregivers are not demonstrating protective actions, and there are no protective actions/safety interventions available and appropriate to mitigate safety threats if the child were reunified at this time.
- ○ Yes. Protective actions/safety interventions have been identified to mitigate safety threats, and caregivers are demonstrating protective actions, including using their support network.

Describe details:

2. Have any new safety threats been identified since the child's removal, or are there any other conditions in the reunification household that, if the child were returned home, would present an imminent danger of serious harm?

- ○ No
- ○ Yes

Describe details:

2a. If yes, are there safety interventions that can and will be incorporated into the family case plan to mitigate these safety threats?

- ○ No. No safety interventions would be available, or no available safety interventions would be appropriate, to mitigate safety threats if the child were to be reunified at this time.
- ○ Yes. One or more safety interventions and at least one support network member has been identified to mitigate safety threats and allow reunification to proceed with an immediate safety plan in place.

Describe details:

B. SAFETY DECISION

○ a. **Safe.** Safety threats that resulted in the child's removal (as documented on the initial safety assessment) are no longer present, and no additional safety threats have been identified. Any safety threats previously identified have been resolved through demonstrated behavioral change and protective actions by the caregivers. **Specific services and support network actions are described in the family case plan to support successful reunification.**

○ b. **Safe with immediate safety plan.** One or more safety threats are present, identified by answering "yes" in question 2 above. **Specific safety interventions and support network actions that will be implemented to mitigate safety threats are described in the immediate safety plan and family case plan.**

○ c. **Unsafe.** One or more safety threats are present, as described above, and interventions are not available or possible to ensure child safety in the home; one or more children remain in care.

Supervisor approval is required for reunification with an immediate safety plan.

☐ Supervisor approval Date:_____

SECTION 2. FAMILY CASE PLAN PROGRESS

CAREGIVER'S PROGRESS WITH FAMILY CASE PLAN GOALS (BEHAVIOR CHANGE, NOT SERVICE COMPLIANCE) SINCE THE LAST ASSESSMENT/REASSESSMENT.

Score based on the caregiver demonstrating the least progress. Note that scoring in this section will carry over to Section 5, Post-Reunification Service Intensity Recommendation.

1. Rate each caregiver's progress with behavior change.

Primary	Secondary	
○	○	a. Frequently demonstrates protective behaviors consistent with family case plan.
○	○	b. Sometimes demonstrates protective behaviors consistent with the family case plan.
○	○	c. Minimally demonstrates protective behaviors consistent with family case plan and has been inconsistently demonstrating protective behaviors.
○	○	d. Does not demonstrate protective behaviors consistent with family case plan.

2. Rate each caregiver's use of support networks.

Primary	Secondary	
○	○	a. Caregiver consistently uses network members and supports available to them.
○	○	b. Caregiver sometimes uses network members and supports available to them.
○	○	c. Caregiver rarely uses network members and supports available to them.
○	○	d. Caregiver refuses engagement and uses no network members or supports available to them.

SECTION 3. FAMILY TIME ASSESSMENT

Assess the caregiver's success with the planned frequency of family time with **each child** in care, as well as the quality of family time. Base your assessment on direct observation whenever possible, supplemented by observation of the child, reports by foster parents or alternative caregivers, etc. Focus on interactions during the period under review (since removal or last assessment).

1. Caregiver's efforts to maintain consistent family time with the child.

Primary	Secondary	
○	○	**a. Consistently follows family time.** The caregiver regularly attends scheduled family time, has few or no missed family time, calls to reschedule if needed, maintains/improves relationship with the child through other allowed communication (e.g., phone, text, social media), participates in other ways to be involved in the child's life as approved, and uses third-party access and unsupervised family time with the child when approved.
○	○	**b. Inconsistently follows family time.** The caregiver frequently misses family time to the extent that it impacts their relationship with the child. Examples of impact may include but are not limited to the child expressing belief that the caregiver will not show up or will cancel family time; or expressing anger, resentment, indifference, and/or sadness due to missed family time.
○	○	**c. Does not follow or is prohibited from following family time.** The caregiver has not engaged in establishing scheduled family time or attending established family time, is prohibited from contact due to court order, or has had family time suspended or curtailed due to the caregiver's behaviors.

2. Caregiver's behavior during family time with the child.

When assessing caregiver behavior during supervised family time, consider the setting; the time of day; the child's energy, development, and emotions; and the limited time the caregiver and child have together in evaluating appropriate limit setting and discipline.

Primary	Secondary	
○	○	**a. Positive interactions.** Previously identified safety threats are not present during family time. The caregiver is consistently protective of the child and can anticipate and respond to the child's individual needs.
○	○	**b. Showing improvement.** The caregiver has improved at demonstrating behavior within the range of healthy parenting responses. Caregiver may demonstrate some understanding of child development, but improvement in anticipating and/or responding to the child's basic needs is needed.
○	○	**c. Unhealthy or harmful interactions.** The caregiver's behavior mostly falls outside the range of acceptable parenting responses. Caregiver demonstrates little to no understanding of child development and limited interest or ability to change parenting behavior or activities.

1. FAMILY TIME FREQUENCY	2. QUALITY OF FACE-TO-FACE FAMILY TIME		
	POSITIVE INTERACTIONS	SHOWING IMPROVEMENT	UNHEALTHY OR HARMFUL INTERACTIONS
Always/often	1a, 2a	1a, 2b	1a, 2c
Sometimes	1b, 2a	1b, 2b	1b, 2c
Rarely/Never	1c, 2a	1c, 2b	1c, 2c

Shaded cell indicates productive caregiver–child interaction. If the result is "1b, 2b" family time could be considered productive with supervisory approval.

Override

○ No override

○ Policy: Family time is supervised for safety.

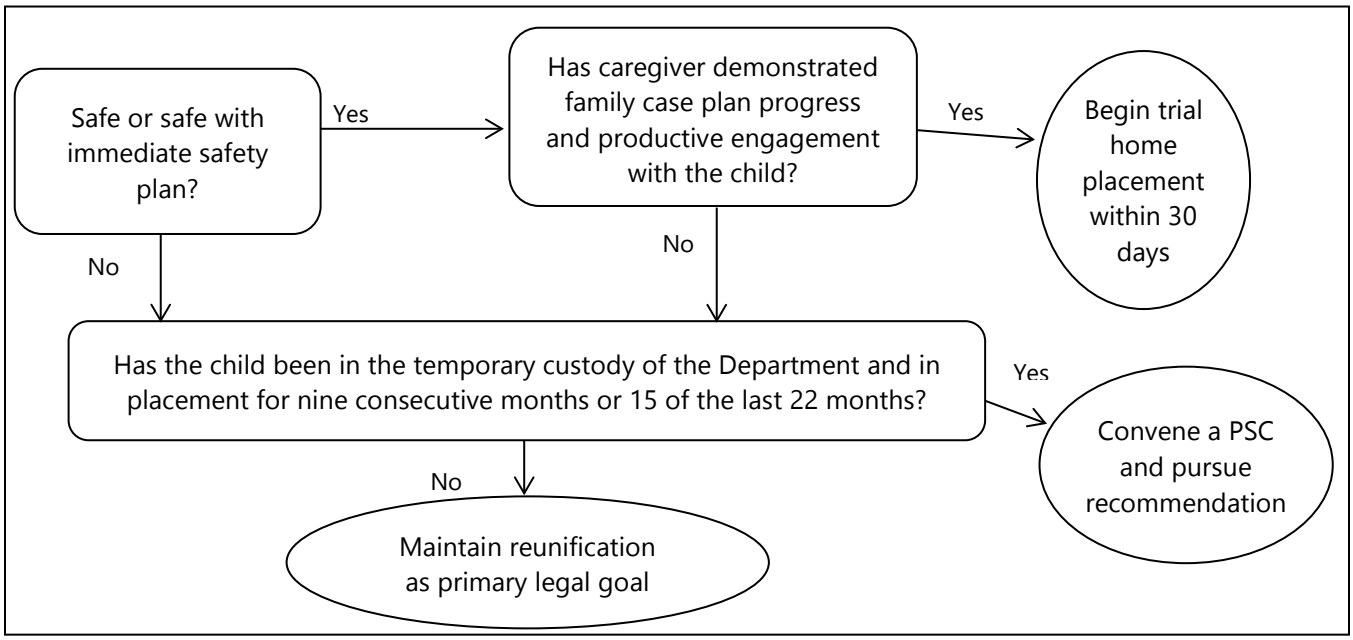
○ Discretionary override: List reason in text field.

☐ Supervisor approval of discretionary override Date:_____

SECTION 4. REUNIFICATION GUIDELINES AND RECOMMENDATION

Section 4 is to be completed for **each child** based on the completed sections above. The output of this process flow is noted in the guideline recommendation section of the table below.

A. GUIDELINES



Discretionary Override

○ No

○ Yes. DCFS is finding compelling reasons to keep the child in out-of-home care; reason noted in box.

Override Reason

☐ Supervisor approval Date: _____

Change recommendation to:

○ Begin trial home placement within 30 days

○ Maintain reunification as primary legal goal

○ Convene PSC and pursue recommendation

B. RECOMMENDATION SUMMARY

CHILD NAME AND ID# (Record recommendation for each child)	GUIDELINE RECOMMENDATION			OVERRIDE APPLIED Y/N	FINAL PERMANENCY PLAN RECOMMENDATION*
	Begin Trial Home Placement Within 30 Days	Maintain Reunification as Primary Legal Goal	Convene PSC and Pursue Recommendation		
1.					
2.					
3.					
4.					
5.					
6.					

*Begin trial home placement within 30 days, maintain reunification as primary legal goal, convene PSC and pursue recommendation, change goal

C. SIBLING GROUP

If at least one child at the time of removal has a recommendation of "Convene PSC and pursue recommendation" 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. They will be considered individually because reunification of siblings is not in the best interest of at least one child. Provide justification for continued separation of siblings:

- ○ Yes. The recommendation for all children will be "Convene PSC and pursue recommendation."

If the recommendation is "Begin trial home placement within 30 days" for any child, continue to Section 5: Post-Reunification Service Intensity Recommendation.

SECTION 5. POST-REUNIFICATION SERVICE INTENSITY RECOMMENDATION

When the recommendation is to begin trial home placement within 30 days, the post-reunification service intensity recommendation is displayed to help determine the level of in-home intervention/services post-reunification.

Initial service intensity recommendation will be followed for the first 90 days; thereafter, the risk reassessment is completed to determine subsequent contact guidelines and timing for case closure.

System logic will display the post-reunification service intensity recommendation based on Section 2, Family Case Plan Progress.

- Households with any "c" or "d" items would require contact guidelines for high/very high service intensity for in-home cases for the first 90 days. (See the following table.)
- Households with all "a" or "b" items would require contact guidelines for low/moderate service intensity for in-home cases for the first 90 days. (See the following table.)

ONGOING WORKER MINIMUM CONTACT FREQUENCY GUIDELINES FOR POST-REUNIFICATION IN-HOME SERVICES		
SERVICE INTENSITY LEVEL	**CAREGIVER AND CHILD CONTACTS**	**LOCATION**
Low/moderate ("a" and "b" from Section 2)	**One to two** face-to-face contacts per month with caregiver and child Plus weekly phone or virtual contact **One to two** collateral contacts	**Must** be in caregiver's residence
High/very high ("c" and "d" from Section 2)	**Three to four** face-to-face contacts per month with caregiver and child Plus weekly phone or virtual contact **Three to four** collateral contacts	**One** must be in caregiver's residence

POST-REUNIFICATION SERVICE INTENSITY OVERRIDE

○ **No override applies**

○ **Discretionary override:** Post-reunification service intensity contact guidelines may be adjusted up or down one level.

Supervisor approval of discretionary override is required.

☐ Supervisor approval Date stamp: _____

SDM REUNIFICATION ASSESSMENT DEFINITIONS

SECTION I. REUNIFICATION SAFETY ASSESSMENT

Every reunification assessment begins with a safety assessment on the household to which the child may be returned. The worker must describe safety threats using caregiver behavior and impact on child and address the safety threats identified at the time of removal and any new or emerging safety threats.

Documentation that addresses how the initial safety threats were mitigated and/or resolved is required. A recommendation for reunification can be made for a child if a safety threat remains; this requires an approved behavior-based immediate safety plan to ensure the child's safety. The immediate safety plan must include at least one person from the family's network (other than DCFS staff) who could not have caused the harm.

A. SAFETY THREATS

1. Are any safety threats (identified on the safety assessment) that resulted in the 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 they were resolved OR, if not resolved, describe the current caregiver behaviors that would pose an imminent danger of serious harm if the child were to be reunified.

How safe would the child be if they were returned home at this time? Consider current conditions in the home, current caregiver characteristics, child characteristics (child's willingness/confidence and capacity to participate in their own immediate safety plan), and interactions between the caregiver and child during family time.

1a. If yes, are caregivers demonstrating protective actions that mitigate the safety threats?

Identify whether any safety interventions are available and appropriate to mitigate any identified safety threats. Use the definitions from the safety and risk assessment procedures manual to review both safety threats and safety interventions, and list what DCFS and the family can do to reduce any barriers. Identify if the family has at least one support network member who could be part of an immediate safety plan.

2. Have any new safety threats been identified since the child's removal, or are there any other circumstances or conditions in the reunification household that, if the child were returned home, would present an imminent danger of serious harm?

Identify whether any new safety threats have emerged during the review period. Review the safety threat definitions. If there are any newly identified safety threats that would pose an immediate danger of serious harm to a child if they were reunified, describe the conditions and circumstances, including caregiver behavior and impact on the child (C + B + I).

2a. If yes, are there safety interventions that can and will be incorporated into the family case plan to mitigate these safety threats?

Identify whether any safety interventions are available and appropriate to mitigate any newly identified safety threats and list what the Division, the family, and the family's support network can do to reduce any barriers.

Use the safety threat definitions and safety intervention definitions to determine whether any new safety threats are present.

B. SAFETY DECISION

a. Safe. If no safety threats are present, as indicated by a "no" answer to questions 1 and 2 in Section 1, mark "a. Safe" to indicate that the child can be recommended for reunification.

b. Safe with an immediate safety plan. If one or more safety threats are present, as indicated by a "yes" answer to either question 1 and/or 2 in Section 1 and interventions are available, documented, and appropriate to mitigate safety threats, mark "b. Safe with immediate safety plan" to indicate that the child may be recommended for reunification with an immediate safety plan in place.

c. Unsafe. If one or more safety threats are present, as indicated by a "yes" answer to either question 1 and/or 2 in Section 1 and no interventions can be put in place to mitigate safety threats, mark "c. Unsafe" to indicate that the child will remain in care. Family reunification must not be recommended when a home is rated "unsafe."

Supervisor approval is required when reunification with an immediate safety plan is taking place.

SECTION 2. FAMILY CASE PLAN PROGRESS

CAREGIVER'S PROGRESS WITH FAMILY CASE PLAN GOALS (BEHAVIOR CHANGE, NOT SERVICE COMPLIANCE) SINCE THE LAST ASSESSMENT/REASSESSMENT.

Score based on the caregiver demonstrating the least progress.

"Family case plan goals" refers to the caregiver's progress with the family case plan related to behavior change and network use. If there are two caregivers, rate the progress for each. If there is no secondary caregiver, only rate the primary caregiver.

1. Rate each caregiver's progress with behavior change

a. Frequently demonstrates protective behaviors consistent with family case plan.

Choose this if the following applies.

- Caregiver is regularly demonstrating behavioral changes identified in the family case plan and is able to create long-term safety for children in the household.
- Caregiver is actively engaged in activities to maintain the outcomes.

b. Sometimes demonstrates protective behaviors consistent with the family case plan.

Choose this if the following applies.

- Caregiver is engaged and sometimes demonstrates behavioral changes consistent with the family case plan.
- Caregiver is trying but is not yet regularly demonstrating the behaviors necessary to create long-term safety for children in all areas.

c. Minimally demonstrates consistent with the family case plan and has been inconsistently demonstrating protective behaviors.

Choose this option if the following applies.

- Caregiver is minimally demonstrating behavioral change consistent with family case plan outcomes and has made little progress toward changing their behavior and is not actively engaged in achieving the outcomes.
- Caregiver's behavior continues to make it difficult to create safety or may contribute to imminent danger of serious harm.

d. Does not demonstrate protective behaviors consistent with the family case plan.

Choose this option if the following applies.

- Caregiver has not demonstrated behavioral change consistent with family case plan objectives.

- Caregiver refuses services, sporadically follows the family case plan, or has not demonstrated the necessary skills/behaviors due to a failure or inability to participate.
- Caregiver is unable to create or maintain safety, and their behavior is likely to contribute to imminent danger of serious harm for one or more children.

2. Rate each caregiver's use of support networks

The term *support network* (or *network*) refers to family, friends, and community supports.

a. Caregiver consistently uses network members and supports available to them.

Choose this if the caregiver relies on informal and/or formal network supports to enhance child safety as outlined in the family case plan.

b. Caregiver sometimes uses network members and supports available to them.

Choose this if the caregiver sometimes relies on informal and/or formal network supports to enhance child safety as outlined in the family case plan.

c. Caregiver rarely uses network members and supports available to them.

Choose this if the caregiver rarely uses informal and/or formal network supports to enhance child safety as outlined in the family case plan.

d. Caregiver refuses engagement and uses no network members or supports available to them.

Choose this if the caregiver is not willing to identify or engage with an informal and/or formal supports available to them to enhance child safety as outlined in the family case plan.

SECTION 3. FAMILY TIME ASSESSMENT

Assess caregiver's actions to maintain engagement with each child in out-of-home care and their behavior with and around the child during family time. Focus on interactions during the period under review (since placement or last reassessment).

1. CAREGIVER'S EFFORTS TO MAINTAIN CONSISTENT FAMILY TIME WITH THE CHILD.

For the purposes of the reunification assessment, family time refers to scheduled face-to-face contact between caregiver and child(ren).

a. Consistently follows family time

Family time is scheduled to occur at a time and place accessible to the caregiver. The caregiver consistently attends scheduled family time, has few or no missed contacts, calls to reschedule if needed, maintains/improves relationship with the child through other allowed communication (e.g., phone, text, social media), participates in additional ways of being involved in the child's life as approved, and uses additional family time opportunities. Examples include but are not limited to the following.

- The caregiver demonstrates commitment to family time by consistently attending scheduled family time for the full time available.
- There are few or no missed or rescheduled family time due to caregiver action. If the caregiver must miss family time, it is rescheduled or canceled in advance. The caregiver demonstrates an understanding of potential impact on the child. If family time has been missed, consider frequency, proximity to other missed or maintained family time, and caregiver's actions to mitigate impact of missed family time on the child.
- Caregiver demonstrates commitment to maintaining/improving relationship with the child through other allowed communication (e.g., phone, virtual family time, text, social media).
- Caregiver shows a commitment to engage in responsibilities of parenthood and actively participates in more ways to be involved in the child's life, such as attending school events or medical appointments.
- Caregiver uses additional family time opportunities when provided and when they are able.

b. Inconsistently follows family time

The caregiver inconsistently attends scheduled family time, has a pattern of unexplained missed family time, or sometimes does not call to reschedule if needed. Caregiver missed family time to the extent that it impacts the child and/or their relationship with the child. Examples of impact include but are not limited to the following.

- Child may express belief that the caregiver will not show up for or will cancel family time.
- Child may express anger, resentment, indifference, and/or sadness due to a pattern of missed family time.
- Caregiver inconsistently participates in additional ways of being involved in the child's life, such as attending school events or medical appointments.

- For missed family time due to illness, distance, or other unavoidable circumstances, consider whether the caregiver has engaged in alternative methods of communicating (phone, virtual family time, text, social media, etc.).
- Caregiver has been inconsistent in accepting family time, even when provided with times that accommodate their schedules and resource limitations (e.g., bus, taxi, gas card).

c. Does not follow or is prohibited from following family time

The caregiver does not engage in establishing family time with the child. Select this if the following applies.

- The caregiver does not engage in establishing scheduled family time or attending scheduled family time.
- The caregiver is prohibited from family time due to court order.
- Family time has been suspended or curtailed due to caregiver behavior.

2. CAREGIVER'S BEHAVIOR DURING FAMILY TIME WITH THE CHILD.

When assessing caregiver's behavior during supervised family time, consider the family's community, traditions, values, and norms; the setting; the time of day; the child's individual needs, energy, development, and emotions; and the limited time the caregiver and child have together in evaluating appropriate limit setting and discipline. Consider the range of caregiver frustration in response to all child behavior.

a. Positive interactions

Previously identified safety threats are not present during family time. Caregiver is consistently protective of the child and is able to anticipate and respond to the child's individual needs. Examples of caregiver behavior may include but are not limited to the following.

- Consistently demonstrates actions outlined in the Family Time Worksheet.
- Anticipates and meets the child's basic needs during family time.
- Demonstrates limit setting and discipline strategies that are developmentally appropriate for the child.
- Demonstrates a focus on child during family time.
- Demonstrates ability to build the child's social and emotional competency. Engages with the child in developmentally appropriate activities and discussions, which may include playing, reading, talking, snuggling, putting child down for a nap, and/or eating.

- Responds to the child's cues and needs in an engaging, supportive manner that builds trust with the child, and shows the ability to co-regulate with the child. Consider the caregiver's verbal and nonverbal responses to the child.

b. Showing improvement

The caregiver is showing improvement in demonstrating behavior within the range of healthy parenting responses. Caregiver may demonstrate some understanding of child development but needs improvement in anticipating and/or responding to the child's basic needs. Examples may include but are not limited to the following.

- Shows improvement and demonstrates actions outlined in the Family Time Worksheet.
- Shows improvement in anticipating and meeting the child's basic needs during family time.
- Recognizes a need to set limits but requires assistance in establishing developmentally appropriate limits and enforcing them in developmentally appropriate ways.
- Needs occasional guidance and support from the worker to focus on and actively engage with the child during contact.
- Demonstrates the ability to build positive parent–child interactions.
- Needs and accepts occasional guidance in providing an appropriate response to child's behaviors, cues, physical and emotional needs.
- Shows improvement in responding to the child's cues and needs in an engaging, supportive manner that builds trust with the child, and shows the ability to co-regulate with the child most of the time. Consider caregiver's verbal and nonverbal responses to the child.

c. Unhealthy or harmful interactions

Caregiver's behavior mostly falls outside the range of acceptable parenting responses. Caregiver demonstrates little to no understanding of child development and limited interest or ability to change parenting behavior or activities. Examples may include but are not limited to the following.

- Does not demonstrate actions outlined in the Family Time Worksheet.
- Demonstrates little or no ability to anticipate and meet the child's needs in a nurturing, supportive, and developmentally appropriate way.
- Demonstrates significant lack of understanding or a complete inability to respond appropriately to the child's cues and behaviors.
- Does not recognize a need to set limits, or sets limits and engages in discipline that is developmentally inappropriate or harmful. Child expresses credible fear of the caregiver.
- Does not demonstrate the ability to build positive parent–child interactions. May also display concerning or harmful behavior toward the child, self, or others during family time. Concerning or harmful behavior occurs regularly during family time or may have been one or more extreme incident.

- Lacks willingness to change parenting behavior to address unsafe behaviors (e.g., lack of supervision, developmentally inappropriate expectations of child, unsafe discipline practices) and does not accept guidance in providing an appropriate response to the child's behaviors, cues, or physical and emotional needs.
- Is disengaged during family time. Examples include being engaged in a phone call or discussion with another adult to the extent that child is not attended to or involved, sleeping when child is awake, or spending the majority of the family time away from the child.

SECTION 4. REUNIFICATION GUIDELINES AND RECOMMENDATION

Section 4 is to be completed for each child, based on completed sections above. The output of this section is noted in the guideline recommendation section of the table.

A. GUIDELINES

Guideline Recommendation

Begin trial home placement within 30 days

The child is eligible to be placed with the household being assessed, based on the reunification assessment results. Take appropriate action to place the child with the caregiver within 30 days **unless conditions change that impact the safety or family time assessment**.

Maintain reunification as primary legal goal

The child must stay in out-of-home care, and reunification efforts with the household under assessment must continue, based on the reunification assessment results. Establish or continue concurrent planning, consistent with practice guidance.

Convene a PSC and pursue recommendation

Recommend changing primary legal goal to something other than reunification (e.g., adoption, guardianship, other planned living arrangement) as indicated by the outcome of the PSC and consistent with policy and practice guidance.

Discretionary Override

Unique considerations warrant an alternative decision. Indicate "yes" when the worker is overriding the recommendation guided by the process flow for each child. Examples of discretionary override reasons may include but are not limited to the following.

- Special considerations related to the child's vulnerabilities require specialized knowledge or expertise to address AND the child's unique needs cannot be met by the caregivers at this time despite agency efforts.
- There is a lack of access to crucial services and resources (e.g., housing).

Note: Supervisor approval is required.

Final Permanency Plan Recommendation

If an override is used, indicate the final permanency plan recommendation: begin trial home placement within 30 days, maintain reunification as primary legal goal, or convene PSC and pursue recommendation.

B. 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 statutes and agency policies and should consult with their supervisor.

For each child being assessed, record the final recommendation.

C. SIBLING GROUP

This section applies only if at least one child at the time of removal was recommended for pursue concurrent plan, and at least one other child has any other recommendation.

Select "no" if siblings will be assessed individually because reunification of siblings is not in the best interest of at least one child and provide required justification. Select "yes" if all siblings will be considered as a group.

If yes, the recommendation for all children will be "convene PSC and pursue recommendation."

SECTION 5. POST-REUNIFICATION SERVICE INTENSITY RECOMMENDATION

This section displays when the recommendation is reunification (begin trial home placement within 30 days) to help determine intensity of services and contact post-reunification.

The Division's information management system will display the post-reunification service intensity recommendation based on the Family Case Plan Progress ratings from Section 2.

Initial service intensity recommendation will be followed for the first 90 days; thereafter, the risk reassessment is completed to determine subsequent contact guidelines and timing for case closure.

System logic will display the post-reunification service intensity recommendation based on Section 2, Family Case Plan Progress.

- Households with any "c" or "d" items would require contact guidelines for high/very high service intensity for in-home cases for first 90 days.
- Households with all "a" or "b" items would require contact guidelines for low/moderate service intensity for in-home cases for first 90 days.

OVERRIDES

If no overrides apply, select "no overrides."

Discretionary Override

A discretionary override is proposed by the ongoing worker whenever the worker believes that the service intensity recommendation does not accurately reflect the household's actual needs. Ongoing workers may increase or decrease the service intensity by one level. If the worker applies a discretionary override, the reason should be specified in the text box and the final reunification service intensity should be marked. Note: Supervisor approval is required.

Initial service intensity recommendation will be followed for the first 90 days then the risk reassessment is completed thereafter to determine subsequent contact guidelines and timing for case closure.

System logic would display the post-reunification service intensity recommendation based on Section 2 Family Case Plan Progress above.

- Households with any c or d items would require contact guidelines for high/very high service intensity for in-home cases for first 90 days.
- Households with all a or b items would require contact guidelines for low/moderate service intensity for in-home cases for first 90 days.

Ongoing workers may increase or decrease the service intensity by one level.

SDM REUNIFICATION ASSESSMENT PROCEDURES

PURPOSE

The reunification assessment helps assess whether children in care who have a reunification goal should:

- Be reunified to the removal household or another household with a legal right to care;
- Be maintained in care while reunification services continue; or
- Transition to concurrent goal for permanency.

The components of the reunification assessment evaluate safety, evaluate caregiver's engagement with the child during family time, describe caregiver's family case plan progress, and record the family case plan goal. The results are used to reach a family case plan goal recommendation and to guide decisions about whether or not to reunify a family. This assessment/reassessment is to be used only with households being considered for reunification. This is NOT to be used to assess potential kinship placements or other potential permanent placements.

WHICH FAMILIES

All families in which at least one child is placed in out-of-home care with a goal of reunification. When caregivers live separately, and each has family case plan objectives to achieve for reunification, separate reunification assessments are required.

If the caregiver you are considering for reunification was not involved and did not live in the home where the abuse/neglect occurred and led to the removal, you would not complete the reunification assessment on that caregiver.

The reunification assessment no longer applies once termination of parental rights has been granted, the child has an official legal goal change to APPLA with no other concurrent goal, or the child has reached the age of 18.

WHO

The worker assigned to the case, with input from individuals who supervise family time, service providers, the children and caregivers, members of the family's network, other DCFS workers, other stakeholders in the case, and the DCFS supervisor. This is meant to be a team effort.

WHEN

DCFS requires a family case plan review at least every 90 days. Each review should begin with an SDM reunification assessment to inform the recommendations made. The reunification assessment should be completed as a team:

- No more than 30 calendar days prior to completing each family case plan or recommending reunification or a change in the permanency planning goal; or
- Sooner, if there are new circumstances or new information that would affect safety status (e.g., network participation now allows for reunification with an immediate safety plan).

If the court orders a child home against the recommendation of DCFS, rather than complete the reunification assessment, you will complete the SDM safety assessment, and if a safety threat is identified, you will complete an immediate safety plan with the family.

A reunification assessment should be conducted when reinstatement of parental rights is being considered.

DECISIONS

Results from the reunification safety assessment and the assessment of parent–child interaction provide a presumptive recommendation for each child: reunification, maintain current plan (reunification), or transition to a concurrent goal for permanency. The family's progress on the case plan provides guidance on the level of service intensity that will most benefit the family.

Note: When the decision is made to reunify a family, interventions by the network and services for the family should continue for a period of time after reunification.

APPROPRIATE COMPLETION

Consistent with the reunification procedures, the reunification assessment process is completed in conjunction with each appropriate household and begins when a child enters care. This requires separate home visits or meetings with each household.

The family case plan is developed with the family within 30 days of the child coming into care so that the family understands what behavioral changes are expected. The reunification assessment should be introduced to the family at the same meeting after creation of the family case plan. Provide the tool in the family's language of origin and use plain language so that family members understand exactly what will be used to assess reunification potential and the goals that the family, agency, and network agreed upon. The tool will be completed with the family/network prior to each family case plan update.

Specifically cover the following with the family.

- Provide information on the reunification safety reassessment, and explain that as soon as safety threats can be mitigated and caregivers can demonstrate actions of protection, the child may return home. They must demonstrate that the safety threats that led to removal have either been resolved or can be controlled by an immediate safety plan involving their network and supports available to them.
- Explain that both the frequency and quality of their family time with the child will be considered, and they must demonstrate engagement by attending planned face-to-face family time and demonstrating productive behavior during contact.

Complete the following for each household participating in reunification services, using the definitions and instructions.

HEADER INFORMATION

Under "Household Assessed," enter the name of the primary caregiver who resides in the household. If this is the household from which the child was removed, select "yes." If this is a household under consideration for reunification other than the household from which the child was removed, select "no."

REUNIFICATION SAFETY ASSESSMENT

Complete a reunification safety assessment. Review the safety threats at the time of the child's removal and how they are being mitigated and/or have been resolved. Indicate whether new safety threats have arisen and how they are being resolved and/or addressed.

Note: If any child is expressing credible fear of returning home, consider if there is a new safety threat present. Determine what the child would need to feel safe, and incorporate that into the immediate safety plan action steps.

A. Safety Threats

Answer questions in this section based on current information. *The worker must review the completed safety assessments, including the safety assessment that was completed at the time of the child's removal,* to ensure that all conditions that resulted in the removal are no longer present.

B. Safety Decision

a. *Safe*. If no safety threats are present, as indicated by a "no" answer to questions 1 and 2 in Section 1, mark "a. Safe" to indicate that the child can be recommended for reunification.
b. *Safe with an immediate safety plan*. If one or more safety threats are present, as indicated by a "yes" answer to either question 1 and/or 2 in Section 1 **and** interventions are available, documented, and

appropriate to mitigate safety threats, mark "b. Safe with immediate safety plan" to indicate that the child may be recommended for trial home placement with an immediate safety plan in place.

c. *Unsafe*. If one or more safety threats are present, as indicated by a "yes" answer to either question 1 and/or 2 in Section 1 and no interventions can be put in place to mitigate safety threats, mark "c. Unsafe" to indicate that the child will remain in care. Family reunification must **not** be recommended when a home is rated "unsafe."

Supervisor approval is required when reunification with an immediate safety plan is taking place.

If any safety threats are present that can be addressed with an immediate safety plan containing protective interventions, ensure the safety plan meets the following requirements.

- The immediate safety plan must include at least one safe adult. This adult cannot be the alleged offender.
- The immediate safety plan should be reviewed at least every 14 days, and sooner if needed.
- The responsibility of providing for the child's safety should be transferred back to the caregiver, replacing formal and agency-provided supports with the family's informal supports as the caregiver's ability is developed or better understood.
- Each immediate safety plan should be feasible and effective, meaning that the worker is confident it will be completed as planned and that it will successfully provide for the child's safety.
- Each immediate safety plan should also employ the skills of the caregiver and family, including any children who are able to participate.
- The immediate safety plan should be focused on immediate actions that will be taken by the family and their support network to create an environment of safety and should not be a list of services. Only services that can help provide immediate safety for the child should be included (i.e., intensive in-home services).

Note: The immediate safety plan details will be documented in the narrative in the case record. The immediate safety plan must be completed *with* the family and their network. A copy should be left with the family and with any network members participating in the plan. The plan must be signed by everyone involved in the immediate safety plan, to indicate that they understand and agree to their roles and responsibilities in implementing the plan.

Note: The immediate safety plan should be documented on the CFS-200: Immediate Safety Plan form.

Immediate Safety Plan Review

Each immediate safety plan should be reviewed with the family and their safety network on or near the review date to ensure the plan is still working. Any modification to the existing plan or any new plan must be reviewed and discussed with the family. The worker should leave a copy of any new plan with the family and any network participants and set a subsequent review date.

FAMILY CASE PLAN PROGRESS

Rate each caregiver's progress with family case plan goals (progress with behavior change and use of support networks) since the last assessment/reassessment. Score based on the caregiver demonstrating the least progress. If there are two caregivers, rate the progress for each; If there is no secondary caregiver, only rate the primary caregiver. This will inform the post-reunification service intensity when the tool recommends reunification.

FAMILY TIME ASSESSMENT

For each child, indicate the level at which the caregiver has participated in the family time plan and the quality of nurturing and caregiving demonstrated during family time. Consult with any others supervising family time, and review all completed family time documentation completed prior to completing this section. This assessment and any related tools used with the family do not replace the requirement to document family time in the information management system.

When completing this portion of the assessment, remember to focus on how caregiver behavior impacts the child and how it is related to identified safety threats. Always consider the child's perspective in making your assessment.

Reunification be considered only when the family time assessment has a **positive rating**. If there is more than one caregiver in a household, the assessment will be completed on the caregiver with the lowest rating.

REUNIFICATION GUIDELINES AND RECOMMENDATION

A. Guidelines

The process flow is used to establish a presumptive recommendation for begin trial home placement within 30 days, maintain reunification as primary legal goal, or convene a PSC and pursue recommendation. Follow the process flow to conclusion.

B. Recommendation Summary

Indicate "Y" in the override column if an override will be used to change the reunification recommendation guidelines for any child, and indicate the final permanency plan recommendation (begin trial home placement within 30 days, maintain reunification as primary legal goal, convene a PSC and pursue concurrent goal) in the next column.

If an override is being used, indicate the reason in the space provided.

A supervisor's approval is required for all reunification assessments/reassessments and when a discretionary override has been applied. A notification will go to the Area Director.

POST-REUNIFICATION SERVICE INTENSITY RECOMMENDATION

The system will populate the post-reunification service intensity level based on the completion of Section 2, Family Case Plan Progress.

- Households with any "c" or "d" should receive more intensive support. Increased support may include planning meetings with the network, referrals for services, additional support, and/or more regular contact by the worker and/or service provider based on the specific needs of the household and children.
- Careful consideration of the family's community context, the child's needs, and the needs of the caregivers should be given when developing a transition plan and recommending services.
- A transition and support plan outlining the supports as they are agreed upon by the worker and the family should be documented in the corresponding Family Case Plan section and shared with all relevant parties.

POST-REUNIFICATION SERVICE INTENSITY OVERRIDE

Select "no override" if appropriate.

Select a discretionary override if the worker feels there is justification for the service intensity level to be moved up or down by one level. Supervisor approval is required.

Final service intensity recommendation will be displayed.

REUNIFICATION/TRANSITION RECOMMENDATIONS

Complete the activities as indicated in the chart below.

REUNIFICATION/TRANSITION ACTION STEPS	
SERVICE INTENSITY	**REUNIFICATION/TRANSITION ACTIONS RECOMMENDED**
Low/moderate	1. Update family case plan (or create aftercare plan) 2. Hold a transition meeting with family and network 3. Develop and distribute transition plan 4. Division allows for less frequent contacts
High/very high	1. Update family case plan (or create aftercare plan) 2. Hold a transition meeting with family and supports 3. Develop and distribute transition plan 4. Division requires more frequent contacts

POST-REUNIFICATION SERVICE INTENSITY OVERRIDE

Select no override applies if appropriate.

Select a discretionary override if the worker feels there is justification for the service intensity level to be moved up or down by one level. Supervisor approval is required.

Final service intensity recommendation will be displayed.

APPENDICES

A. HOUSEHOLD CONTEXT PRACTICE GUIDANCE

B. FAMILY CASE PLAN TOOL PRACTICE GUIDANCE

C. HOUSEHOLDS

APPENDIX A: HOUSEHOLD CONTEXT PRACTICE GUIDANCE

PRACTICE GUIDANCE FOR ASSESSING HOUSEHOLD CONTEXT

All families have multiple aspects of self-image and unique community connections that shape child-rearing and family functioning and provide valuable context to better assess and plan with families.

This is a guide for assessing a family's household context in practice, both when assessing safety and throughout a case, to learn how community connection shapes and influences beliefs and values about child development and parenting norms and strategies. Attention to the unique context of *every* family is critical to the development of individualized and strength-based responses.

This guide is a tool to increase understanding of the value and relevance of family and community context and to provide strategies for applying this understanding to casework and decision making regarding child safety and well-being.

When workers set the tone of the relationship and engage families in dialogue about themselves from the start, they can build the trust necessary for ongoing casework. Examining aspects of the family's community and self can help workers to more accurately identify a family's protective capacities and actions and determine the appropriate threshold for safety threats in the context of the family and community.

Domains to explore include race; ethnicity; faith, spirituality, and religion; education; military status; ability status; sex (including pregnancy, sexual orientation, and gender); national origin; immigration status; socioeconomic status; history of addiction and mental health; medical background; personality type of each family member; child developmental milestones; parenting norms in family of origin; and so forth.

STEP 1: PREPARE TO WORK WITH THE FAMILY

Understand Your Own Biases

- Be mindful of your own beliefs, values, norms, and gaps in knowledge.
- Recognize the limits of your understanding about particular groups.
- Be willing to seek information and advice. Use the resources at your disposal.
- Everyone holds positive and negative biases about various groups that can play out in relationships and in work with children and families. Being aware of these biases and preparing in advance in relation to them can reduce miscommunication with families.

- Stay focused on assessment of imminent risk of serious harm, not complicating factors. For example, avoid unintentionally criminalizing poverty and parenting norms and values that differ from your personal experiences.

Research and Reflection

- Prior to interviews, try to find out what differences exist between you and the family and learn about any common beliefs and practices relating to parenting and child protection within the family's community.
  - » Identify the community variables you already have fluency with.
  - » Notice community context differences that make you feel uncomfortable or that you are less knowledgeable about.

    Work with your supervisor to identify the communities you have little exposure to or experience with. Then, brainstorm good questions you can ask to learn more before the first interview with the family. Beginning with the understanding that every family values and believes things based on many facets of their community context, approach the first interaction with a family with the following goals.
    - – Listen to the family's story while maintaining both your desire to understand and your expertise in assessing safety.
    - – Do so within the family's context by knowing your biases.
    - – Be prepared to use strong inquiry skills.
    - – Prepare to set a positive and open tone that builds a bridge across any difference.
    - – Use this difference as an asset for planning and decision making.
- If family members are immigrants or refugees, contact local support agencies to learn more about the family's country of origin, including its ethnic demography, religion, and migration to and settlement in the United States; and the experience of state-based or interpersonal trauma of families from that country.
- Contact other agency or community workers who can share knowledge about family engagement across differences while ensuring the family's confidentiality. Speaking with multiple sources when possible will provide a broader understanding. While general knowledge of particular subgroups is important, we must remember that families are not one-dimensional.

Prepare to Engage

- Remember that the family is the expert about themselves and the most important source of understanding the ways that their communities and systems influence their functioning, decision making, and assessment of safety and well-being. It is good to think of questions that help you elicit information relevant to the purpose of the assessment; for example, what families' bedtime routines are; how they express joy, anger, or sadness; how they eat meals; and their beliefs about discipline and health. When you talk about community context and beliefs through actions, expressions, and activities, families may be able to provide you with more information.

- Be prepared to acknowledge and name the differences between you and the family aloud, including the power differential.
- Seek to understand the family's perspective about their lives and their decision making. Ask "how" rather than "why" when trying to understand their context and beliefs.
- Come from a place of humility and lead the conversation with transparency and a willingness to tolerate any discomfort you may have discussing topics with a family.
- Prepare solution-focused questions to engage each family member and network member to learn as much as you can about their unique characteristics. (See second point above.) For aspects of self that may be sensitive, ask what they would like to keep confidential.
- Conversations and engagement about families' beliefs and community connections should happen consistently throughout the life of the case. Families will share more details over time as trust builds. Each worker can build upon the information gathered by the previous one.

STEP 2: FAMILY ENGAGEMENT

Pre-Interview

- If you are aware of the primary spoken language and dialect of the family, this would be a good time to identify key words related to the concern and the child's safety. This does not take the place of a translator but does convey that you are working to make connections, and it can contribute to targeting the conversation. For example, "The child is safe to stay in the home" in Marshallese is "Ajiri in ejokne im eman kijien ilo mwiin."
- If family members speak a language that the worker does not, first identify which dialect of the language the family speaks and then identify a professional interpreter who is fluent in the same dialect to support navigating conversations with the family. When possible, use the same interpreter every time you meet. Allow the family to determine if the translator would be in person or by phone.
- Use the tools available to you such as the ecomap, Circles of Safety and Support, and genogram to understand how family members define their safety network and community of peers. This is a valuable piece of information for ongoing assessment and planning.
- Ask the family if they would like to invite anyone from their family group or network, church, or community to attend (e.g., tribal elder, faith leader, community representative).

During the Interview

- Use clear, plain language. Avoid acronyms, long sentences, informal English phrases and idioms, unnecessary detail, and professional jargon.
- Name and acknowledge the differences between you and the family and share your commitments. For example:

  "By law, DCFS has to make sure families are safe, and we want to do that together with your family in a way that you understand and that helps you feel I understand you. I recognize that DCFS has the

power to involve the court system, push you to do things that may not be easy to do, and make decisions that may feel bad or hurt you. This can be scary and feel threatening to you and your family."

"I want to hear what you need and want to be sure that your child is safe. I want to work with you to keep your family together and get any resources and support you may need to do this. DCFS has the power to make decisions about your family, and that can feel scary and intimidating."

"I am committed to being transparent with you and your family about my work and to making sure you have a say in what happens. I am also committed to learning about your family's community and how that shapes how you run your household and raise your kids."

- Pay attention to family members' cues. If the family seems uncomfortable discussing aspects of their community for fear of judgment, family network dynamics related to information-sharing or perhaps intimate partner violence, or confusion: Break the conversation down into smaller parts, being clear about the concern at hand and the specific options to resolve it. Allow the family time and space to share more about themselves and their day-to-day life; the family is the expert on their story, and you taking the time to understand them allows them to know that you care about them.
- Create a safe space for youth by taking the time to ask where they would like to meet and what would help them to be more comfortable participating in this process. Allow time for them to ask questions that will help to build the bridge of communication. Enter conversations with all youth with a statement that conveys openness and awareness for youth to speak freely about themselves.
- Pay attention to both process and content for yourself and the youth. For yourself: Be aware of your nonverbal reactions, especially if a youth discloses something different from what you anticipated. Your reaction can shift the dynamics of the conversation. For the youth: Be aware of their nonverbal reactions as they share information. For example: The youth may say that they are doing great and want to stay in a home; but their nonverbal reactions could show sadness, indicating the opposite.
  - » What name would you like me to call you? I go by _____.
- Stay curious and explain that you will ask multiple questions, even when it seems obvious, to better understand their unique family context and how it connects to household functioning and parenting practices.

  Sample Questions
  - » How would you describe parenting practices or norms that are important to you?
  - » Are they connected to your family history in a way that you want me to know about? How do they show up in your day-to-day life?
  - » Are there any other aspects of your family's values and norms that you think would help me better understand where you are coming from?
- Be prepared to articulate the connections between their values, norms, and activities; and the impact on their child's safety and well-being. For example, when a family talks about protecting privacy and you assess that there is a multigenerational tradition of secrecy, explain that when families can learn to trust other people, they can feel less isolated and more supported in making behavioral changes that will increase child safety.
- Summarize what you learned from the family and ask whether you got it right.

STEP 3: PLANNING

In Home

- Adopt a supportive role where possible and provide assistance in the form of concrete, relevant services as quickly as possible, whenever possible.
- Ask families what has worked or not worked for them in the past and, if appropriate, their preferences for any actions they can take to increase safety.
- Include action steps, with behavioral detail, to mitigate safety threats on the plan—not just a list of services (which go on the family case plan) or vague expectations. Consider details of *how* the caregiver will demonstrate the actions in daily parenting activities in ways that are contextually specific and relevant—and how network members can support them. Families will struggle if asked to conform to community or social expectations outside of their own; allow them to explore action steps that promote change and healing that they relate to and connect with.
- Facilitate a conversation to help families identify their safety networks using the Circles of Safety and Support tool and support network grid.
- Include key words in the family's language.
- Include network members in the plan to provide emotional support and monitoring functions.
- Ensure that sensitive information about a child is not documented anywhere that will be shared with others without the child's permission, including on the safety or family case plan.

Out of Home

- When out-of-home care is necessary, work diligently within the family's community to identify a resource parent. Provide an interpreter for the family when the resource parent's language is different from the parent's.
- Ask the parent about their child's self-image and perception and what they would like shared with the resource parent.
- Ask the child what information about themself they would like to remain confidential. Unless provided with explicit permission to share and document sensitive information about a youth, ensure that sensitive information is not documented anywhere that will be shared with others.
- Create icebreaker opportunities for the parent and resource parent to meet when possible to help the resource parent better understand what the child needs in order to remain connected to their community and belief systems while in care. *Provide an interpreter for the family when the resource parent's language is different from the parent's*.
- Ask the resource parent to share insight about their family's community connections and beliefs. The child will have cross-community experiences at this point even if, for example, the resource family is the same race/ethnicity as the family of origin.
- Arrange family time with consideration of what is important to the family, supporting the family to engage in traditional gatherings and celebrations. With the family's permission, reach out to leaders or organizations in the community to learn more about the family's community context to ensure

that contact between the child and their community remains a priority—for example, the child can attend faith-based services with a relative; have regular sibling visits; or participate in birthdays, traditional holidays, or the annual family reunion.

- Help the resource family learn about the family's values and background. Ensure they are committed to upholding the family's values and supporting the child's connection to their community of origin; create a plan to support any disconnects or gaps. For example, if the child comes from a family that belongs to one religious tradition and is placed with a family that participates in a different religious tradition, create a plan that allows the child and family to respectfully coexist without the child being labeled "noncompliant" or "oppositional."

STEP 4: DOCUMENTATION

Workers are expected to document how the family identifies along with how their beliefs and values affect their parenting norms, child safety, and well-being. Workers must summarize these discussions and what they learned (rather than guessing or assuming) and share how an understanding of the family's values and norms is incorporated into assessment and planning throughout the life of a case. Here are a few tips for behavior-oriented detailed documentation.

- Include the questions asked during interviews with parents, network members, and collaterals.
- Write how the family identifies in each domain inquired about. Never guess an aspect of a family's community or affiliation (country of origin, ethnicity, race, religion, etc.).
- When documenting household context, summarize the connections between the family's various beliefs and values and their parenting norms and behaviors.
- For example: Mom identifies racially as White; ethnically, she is Irish and French. She stated that she grew up in a strict fundamentalist Christian home, went to church weekly, and was physically disciplined as a child with a wooden spoon that often left marks on her behind. Her parents always said, "The Bible says spare the rod, spoil the child." She feels that she turned out fine, so she has continued using the same discipline with her own children.
- Be explicit about how an immediate safety plan or family case plan was made to be specific to their values and beliefs.

  Immediate Safety Plan Example

  - The family relies on their congregational church pastor for counseling and advice when struggling with poverty and the father's drinking. The pastor agreed to be part of the family's safety network and will be part of the immediate safety plan.
  - A 12-year-old boy, Mateo, lives with his grandmother, who speaks limited English. Recently, concerns arose about Mateo's safety when his father, who struggles with alcohol use and sometimes becomes aggressive, began staying in the home. The caseworker involves a Spanish-speaking facilitator to ensure Mateo and his grandmother, father, and support network fully understand the plan and can communicate their worries, needs, and suggestions The caseworker provides a copy of the immediate safety plan in Spanish and English. A 4- and 6-year-old were left alone for eight hours while their caregivers were at work. The family chooses

to use a close, trusted family friend to assist with childcare while the caregivers are unavailable, so the 4 and 6 year old are not left without supervision.

Family Case Plan Action Examples

» Mom is Buddhist and prefers Eastern medicine practices. She has always counted on her Reiki practitioner to help her maintain sobriety, so going to Reiki at least once every two weeks is now included in her family case plan activities.

» Kimberly's resource parents agree to support her Marshallese community connections by transporting her to Marshallese language classes and other classes through the Marshallese Educational Initiative.

- Document how a caregiver is attending to the child's community connections and beliefs and helping them to remain connected. For example: The resource parents attend Catholic Mass on Sundays and have given Levi the option to attend Shabbat with a Jewish family friend on either Friday night or Saturday morning. When the resource family is at Mass, Levi has a babysitter or stays with the family's neighbor. Levi's parents have expressed gratitude that they are not forcing him to attend Mass with them and that he can maintain his Jewish faith and traditions.

APPENDIX B: FAMILY CASE PLAN TOOL PRACTICE GUIDANCE

This material provides examples for the three steps of the planning process that must occur for each caregiver and child area.

1. **Information gathering**. Use the sample questions to gather information to inform the item response.
2. **Prioritization**. Use the sample questions to help determine the extent of this area's impact on the children's safety, permanency, and well-being.
3. **Planning**. See the examples of desired outcomes, actions, and optional formal or informal services to consider for the family case plan.

USING THIS RESOURCE

1. During the information-gathering step, first determine whether any information is lacking. Then, for each assessment item in need of additional information, review the sample information-gathering questions. It is unlikely that the information you need and the sample questions will match exactly. However, the sample questions can inspire better questions to ask the family and safety network in order for you to finalize each item's rating.
2. Once all items are rated, identify all "needs identified" items. Work through the prioritization decision tree for each area. Locate the item in this resource and refer to the prioritization questions for ideas on ways to ask specific prioritization questions. Continue until each "needs identified" area is prioritized.
3. Once all "needs identified" areas are prioritized, review the areas selected for inclusion in the current family case plan. For each item, locate the item in this resource. In partnership with the family and their safety network, complete the following.
    a. Select a *desired outcome* for each item. The examples are unlikely to adequately reflect each family's unique situation but can serve as conversation starters. State an outcome that is clear enough and represents a condition that, if present, would make everyone feel comfortable about the child's ongoing safety.
    b. Given the desired outcome, consider what specific *actions* the caregiver needs to take in order to reach the goal. The examples are unlikely to perfectly reflect actions needed in each family but can serve as ideas if the family and safety network are having difficulty generating their own ideas.
    c. Given the actions the caregiver needs to take, consider whether any external *resources* could help the caregiver be successful. These resources may be formal services or informal supports. The examples are unlikely to precisely match both the supports needed *and* those locally available. However, the examples may stimulate thinking of options.

When using this guide, please keep the following statements in mind.

- This guide provides *examples* of questions to help guide conversations with families regarding the family case plan tool. The questions are not required, nor are they exhaustive. Use your professional judgment to decide whether each question is appropriate for each caregiver or child.
- For each scaling question (i.e., on a scale of 0 to 10) directed at the caregiver, consider reframing the question with respect to caregiver willingness, ability, and confidence to address family and child needs.
- Incorporate observations of caregiver and child behavior when completing areas.
- While the questions in this guide are directed toward children, caregivers, and placement caregivers, you also may choose to use the questions to collect information from relevant collateral individuals (e.g., medical care providers, teachers, daycare providers). Consider information from all sources when completing the family case plan tool.
- Regardless of the information collected, use *only* the family case plan tool definitions to answer the items. Additional information may help you develop an appropriate family case plan.

Document your family-planning conversations with families in assessment, as well as your home visit contacts, in the agency database.

CAREGIVER AREAS

1. RESOURCE MANAGEMENT/BASIC NEEDS

INFORMATION GATHERING		• On a scale of 0 to 10, where 10 is that you have all the money and resources you need to pay your bills and keep food on the table, and you never have large worries about money; and 0 is where you constantly worry about paying for basic needs such as food; where are you? • It is difficult to care for a family when there are more needs than can be met by the money coming in. How have you managed to make things work so far? • Was there ever a time in the past when you were struggling financially and found a way to make ends meet? How did you do that? • Do you or someone else in the home ever go hungry? • Was there a time when you thought about spending money in one particular way (e.g., gambling, alcohol) but instead decided to use the money for basic family needs? What made it possible for you to make that decision? • If your [child, mother, trusted friend] were here, what would they say about how you manage your finances? • What needs to happen so that you have the resources to support your family? Have you thought about other kinds of employment? What would need to happen for you to pursue that?
PRIORITIZATION		• Did financial pressure have anything to do with: » Caregiver's physical outburst? » Dependency on offender? » Vulnerability to intimate partner violence? » Not providing: ▪ Safe shelter? ▪ Medical care? ▪ Food? ▪ Other kinds of supervision? • Will the family have the resources they need to ensure basic needs are met?
PLANNING	**DESIRED OUTCOMES**	• Caregiver provides the resources needed by the family to . . . • Caregiver partners with safety network in order to ensure family and children have basic needs met.
	ACTIONS	• When caregiver worries about money, caregiver will . . . • When stress is high, caregiver will . . . • In order to meet basic needs, caregiver will budget for . . . • In order to ensure basic needs are met, caregiver will reach out to . . .
	RESOURCES	• Nonprofit debt consolidation assistance • Food banks • Job • Financial help from church • Financial help from safety network • Social services

2. PHYSICAL HEALTH

INFORMATION GATHERING		• Tell me about your physical health. • How do you keep yourself healthy? • Do any aspects of your physical health make it harder for you to be at your best as a parent? • You mentioned you have [chronic condition], and I would like to get a sense of how that affects your life. On a scale of 0 to 10, where 10 is that you barely even know you have it and you can manage it in less than a minute a day; and 0 is where not a minute goes by that you don't think about it, and almost every daily task is harder because of it; where are you? • What is it like having to parent a child of [child age] when you have [condition]? • How long have you had [condition]? How long is it expected to last? • What is important for me to know about [condition]? • Having [condition] can be really hard on people. How have you managed as well as you have?
PRIORITIZATION		• If caregiver did not have [condition], would the safety threat have happened anyway? • Will [condition] make it hard for caregiver to make the changes needed to create safety? • Will growing up with a caregiver with [condition], given this caregiver's current management of [condition], get in the way of child's school, social, emotional, or physical opportunities?
PLANNING	**DESIRED OUTCOMES**	• Caregiver is healthy and physically able to provide everything the child needs. • Caregiver manages [condition] so that child's needs can be met. • Caregiver and safety network work together so that someone from the safety network is there to do whatever caregiver cannot.
	ACTIONS	• Caregiver and medical provider create a workable plan of care. • Caregiver agrees to share information from the medical plan of care with worker as needed. • Caregiver follows plan of care. • When caregiver is tempted to skip part of plan of care, caregiver calls safety network member who will help. • Caregiver and safety network create a plan that will be followed each week so that someone is always available to drive child when needed, i.e., if caregiver cannot drive a car for health reasons. • Caregiver and safety network create a plan so that someone comes to fix meals every day for the next three weeks (e.g., for acute illness). • Safety network member will help caregiver set up a medication plan so caregiver has reminders to take medication.
	RESOURCES	• Medical consultation or evaluation • Condition-specific support groups • Public health nurse

3. PARENTING PRACTICES

INFORMATION GATHERING		• When you think of your parenting abilities, what makes you most proud? What do you do best as a parent? • What works best when you are trying to teach [child] right from wrong? • Many parents struggle when their children are [infants, toddlers, teenagers]. How do you manage? • What does your child need most from you at this time? • What are the lessons you took away from your parents as they raised you? • Every parent reaches the end of their rope. What do you do then?
PRIORITIZATION		• Is there something important the caregiver does not know about parenting or a skill the caregiver does not have that has contributed to an unsafe situation? • Is it the case that unless caregiver [gains specific parenting knowledge] or [develops a particular parenting skill], it is unlikely that the child can remain safe? • With the current level of parenting knowledge and skill, is it possible for child to feel safe, secure, and a sense of belonging; and to develop to the best of their potential?
PLANNING	**DESIRED OUTCOMES**	• Caregiver knows and demonstrates what [child] needs from them and provides it. • Caregiver knows when tensions are mounting and creates safe alternatives in plenty of time so that everyone stays safe. • Caregiver knows and practices at least three safe ways to handle situations in which child cries inconsolably.
	ACTIONS	• Caregiver reads (or requests assistance reading) or watches provided material about child development and parenting tips. • Caregiver seeks advice from trusted parenting mentors or safety network members. • Caregiver identifies three actions to take when situations arise that have been difficult for them in the past. » Role-play practice with safety network member » Demonstrate during contact with child » Keep a journal describing practice opportunities
	RESOURCES	• Selected, preapproved parenting websites • Triple P (parent coaching) • Parent–Child Interaction Therapy • Trusted relative or spiritual leader • Resource parent • Parenting classes (*careful*: Must be community- and age-relevant and focused on target issues) • Home visiting programs, such as Intensive In-Home Services, SafeCare, ZERO TO THREE, etc.

4. SOCIAL SUPPORT SYSTEM

INFORMATION GATHERING		Note: If you have not done a genogram or family tree with the family, it would be helpful to do one prior to rating this item. • On a scale of 0 to 10, where 10 is that you have all the people you need to help you out when you are in trouble and 0 is where absolutely no one would help you out, where are you? • Tell me about times in the last several months when people helped you out when you needed it. Who was it? • Who are the three people you trust most? Where are they? When did you last speak with them? • Who has surprised you by coming through for you? • Who has surprised you by not being there for you? • If I asked these people, would they say they also count on you? What stories would they tell me to show how you came through for them?
PRIORITIZATION		• Did caregiver's current support system or lack of social support contribute to the unsafe event or pattern? • Without more or different support, will it be possible for caregiver to make the changes needed to create safety? • Given the level of isolation, will the caregiver be able to meet the child's needs?
PLANNING	**DESIRED OUTCOMES**	• Caregiver feels supported and connected to others in a way that means they can be at their best as a caregiver. • Caregiver reaches out to ask for and accept help when responsibilities start to feel overwhelming.
	ACTIONS	• Caregiver will identify additional supports that may be added to their safety network and have a conversation with them about the unsafe event and the kind of support they need. • Caregiver will call someone from safety network daily to talk about relevant topics. • Caregiver will attend a support group or get a sponsor. • Caregiver will join activities at house of worship or other community organization and get to know people who may be added to their safety network. • Caregiver will invite [person] to a family team meeting.
	RESOURCES	• Therapy to address social skills, social anxiety • Social support groups (e.g., AA, NA, parent support groups, Celebrate Recovery, intimate partner violence support groups, and autism support groups) • Natural resources (e.g., relatives, fictive kin, churches, schools, daycares, Head Start, and mentoring programs)

5. HOUSEHOLD AND FAMILY RELATIONSHIPS

INFORMATION GATHERING		• How did [other adult household members] end up living with you? How long have you been sharing a residence? How long do you expect to share a residence? • What working agreements do you have with each other regarding financial responsibilities? Chores? Access to living space? • On a scale of 0 to 10, where 10 is that you are grateful for [person] living with you and making life better for you and your child and 0 is that you are completely miserable sharing living space with [person] and cannot wait to be on your own, where are you? • What is the best thing about having [person] live here with you? • It can be hard for [relatives, unrelated adults] to share a place to live. How have you and [person] managed to make this work?
PRIORITIZATION		• Does [person] create a safety threat for child? • With [person] in the household, will it be difficult for caregiver to make the changes needed to create safety? • Does [person]'s presence get in the way of caregiver providing the parenting needed by the child to be emotionally and physically healthy?
PLANNING	**DESIRED OUTCOMES**	• All of the adults in the household work together to create a safe place for [child]. • If the caregiver feels that relationships with other adults in the household are putting the child at risk of harm, the caregiver will make alternative living arrangements to increase child's safety.
	ACTIONS	• Adults write up agreements about [issues that create conflict] and follow them. • Caregiver participates in a family meeting to identify what needs to happen to create effective relationships with [person]. • Caregiver secures living quarters independently if needed. • Caregiver and/or worker will share safety plan with children, if age appropriate, so children know what to do in the event of intimate partner violence.
	RESOURCES	• Counseling to address unresolved issues between adult relatives • Family meeting to work on living arrangements • Housing resources to help secure independent housing

6. INTIMATE PARTNER VIOLENCE

INFORMATION GATHERING	[Note: You may want to divide these questions/planning examples into offending and non-offending caregivers] • How do you and [partner] get along? • How do you and [partner] make decisions about money/how to spend your time? • When [partner] does not do what you expect, how do you manage? • Do the two of you plan to continue to be a couple? Is that important to you? • What are you willing to do in order to make your relationship successful and keep the children safe? • Was there a time you wanted to hit your partner but chose not to? What did you do? How was that possible? • On a scale of 0 to 10, where 10 is that you feel completely safe physically and 0 is where you are terrified every day that [partner] will seriously hurt you, where are you? • If [partner] were here, how would they describe you? • In the past year, have you been injured by [partner]? • How does your best friend feel about your relationship with [partner]? • Many parents in similar situations find it hard to be the best parent they can be when they feel scared. How have you managed? • What have you learned are the best ways to protect [child] when you are aware that your partner might soon be violent? • What have you tried in the past to keep yourself and your children safe? • Have your partner's actions ever made it difficult for you to take care of the kids the way you want to? • Do you ever regret how you have treated your partner? • Is your partner ever afraid of you? • Are your children ever afraid of you? • How do your partner's actions support your parenting? How do your actions affect your partner's parenting?
PRIORITIZATION	• Did intimate partner violence create physical danger for [child]? • Did controlling behavior prevent one caregiver from providing basic needs for [child]? • Is living with intimate partner violence creating trauma for [child] to the extent that they are suicidal, self-harming, or violent towards others? • Can caregiver make the changes needed to create safety if intimate partner violence is not resolved first? • If [child] continues to experience this level of violence, power, or control, can they perform at their best in school or develop healthy relationships?

PLANNING	**DESIRED OUTCOMES**	• Caregiver creates a safe and supportive household for the children. • Caregiver ensures children are never exposed to one partner hurting the other. • Caregivers will behave in ways that allow each caregiver to successfully nurture the children. • Caregiver will refrain from physically hurting their partner. • Caregiver will refrain from attempting to control their partner's finances. • Caregiver will refrain from attempting to control their partner's social contacts. • Caregiver will ensure that any new partner will meet the safety network prior to meeting the children.
	ACTIONS	• Both caregivers will create a safety plan including financial safeguards, legal safeguards, and escape plans. • Caregiver and/or worker will share safety plan with children, if age appropriate, so children know what to do in the event of intimate partner violence. • [Offending caregiver] will identify and practice things to do when they are becoming violent. • When [offending caregiver] feels angry and about to lose it, they will tell family they need 10 minutes and will go for a walk. • [Offending caregiver] lives someplace else until they is able to demonstrate nonviolent ways to manage disagreements [*Note*: A plan for likely contact between the caregivers should always exist, even if one caregiver chooses to move away]. • Caregivers decide whether to seek divorce.
	RESOURCES	• Shelter (formal or with friends; mindful of security) • Batterer groups or training • Legal services for restraining orders or divorce, if selected • Informal networks for both caregivers • Survivor groups

7. SUBSTANCE USE

INFORMATION GATHERING		Note: FSWs are encouraged to use the UNCOPE or similar tool. • What role does substance use play in your family? What specific substances are used and how often? • Does someone in your life worry about your substance use? • How would you describe the difference between how you are when you have had a drink or more and how you are when you are not drinking at all? • Have you ever wanted to use badly but didn't? What made that possible? • What has substance use cost you in terms of your work, your finances, your relationships, or legal implications? How has substance use impacted your life? • How has your use of substances affected your ability to care for your children? If your child was here, what would they say? • Do you have a history of substance use? How much of the time have you been using, and how much of the time have you been clean/sober? Have you received help for drinking or using? (When, where, how well did that work?) Can we make a timeline? What happened right before you got clean and sober here? What happened right before you started using here? • On a scale of 0 to 10, where 10 is that alcohol and drugs have no role in your life at all—you never drink or use and have no desire to—and 0 is you barely have a moment that you are not high or drunk, where are you? • Have you heard from other people about things you did while using that you do not remember?
PRIORITIZATION		• Was caregiver under the influence when the safety threat occurred? • Can caregiver follow a family case plan given their current substance use? • If nothing changes, will [child] be able to succeed in school, have healthy social relationships, develop emotional health, and develop a healthy relationship with alcohol and drugs as an adolescent and adult?
PLANNING	**DESIRED OUTCOMES**	• Caregiver will always be clean and sober when responsible for [child]'s care. • Caregiver will pursue a life free from substance misuse and will have and follow a relapse plan.
	ACTIONS	• When caregiver thinks about using, caregiver will reach out to safety network for support to prevent relapse and/or to secure childcare. • Caregiver will work with counselor, safety network, and/or worker to develop a treatment plan as well as a relapse prevention plan as needed. • Caregiver, counselor, and/or worker will share safety plan with children, if age appropriate, so children know what to do in the event of substance use relapse. • Safety network member [name] will agree to provide support with treatment plan compliance and relapse prevention plan. • Caregiver will agree to have their substance misuse treatment and progress verified by the worker.
	RESOURCES	• Professional evidence-based substance misuse intervention • Support groups • Sponsor • Faith-based groups, tribal groups • Random drug testing if necessary

8. MENTAL HEALTH

INFORMATION GATHERING		• Have you noticed any change in how you are eating or sleeping? • What do you enjoy doing? Are there things you used to enjoy that you don't anymore? • How much of the time do you feel sad? Anxious? Afraid? Happy? • If someone who is close to you talked to me, what would they say is worrisome about you? • Have you ever received professional support for how you were feeling? (When, how long, with whom, how did that work for you?) • Have you ever felt like giving up? (When, what changed?) • You said you feel sad all the time. Has there ever been a time, no matter how brief, when the sadness was not there or was not as strong as usual? What was going on then? • Do you hear or see things that others do not?
PRIORITIZATION		• Did caregiver's behaviors related to mental health create a safety threat? • If caregiver remains [depressed/anxious/out of touch with reality], will caregiver be able to make the changes necessary to create safety? • If nothing changes, will a child living with this caregiver be able to feel safe and secure enough to function in school and social settings and develop their own emotional health?
PLANNING	**DESIRED OUTCOMES**	• When caregiver is overwhelmed with feelings of [depression/anxiety], they will always act to ensure [child] is safe and secure. • Caregiver will act to reduce the impact of [depression/anxiety/schizophrenia] on their own life; when it does affect their ability to meet child needs, they will act to ensure child safety.
	ACTIONS	• Caregiver will take medication as prescribed and ask for support if struggling to do so. • Safety network member [name] will agree to provide support with medication and treatment plan compliance. • Caregiver will agree to share information on the treatment plan with the worker. • Caregiver will make time every week to practice self-care, such as walking, cooking, knitting, reading, or meditating, based on activities they enjoy. • Caregiver will work with therapist to change patterns of thinking that keep caregiver stuck. • Caregiver will keep a journal with a minimum entry being a 0 to 10 scale for each day where 10 is the best they have ever felt and 0 is the most [depressed/anxious] they have ever felt. • Caregiver will participate in family meetings to build safety network for support. • Safety network will check in with caregiver [X] times per week to offer support. • Caregiver will give permission to the safety network to contact the worker if they are worried the plan is no longer working. • Caregiver, therapist, and/or worker will share safety plan with children, if age appropriate, so children know what to do if the caregiver's coping skills or mental health become a concern.
	RESOURCES	• Individual therapy such as cognitive behavioral therapy (CBT) or trauma-focused CBT • Support group • Mental health hotlines • Local mental health authority • Mental health consult

9. PRIOR ADVERSE EXPERIENCES/TRAUMA

INFORMATION GATHERING		Note: Consider using the Adverse Childhood Experience (ACE) questionnaire for this section. • Can you tell me about your childhood? What was it like for you? • Have you ever experienced upsetting events? What happened? How do you manage or deal with that? • Do memories or intrusive thoughts of upsetting events come into your head even when you do not want them? • Are there things that happened to you in your childhood that make you feel bad about yourself? • What are three words you would use to characterize your childhood? • Are there issues, traumatic incidents, or accidents from your life that currently cause you distress? If yes, please explain. • When you were a child or adolescent, did you require counseling or psychiatric care? • Have you ever had a sexual experience that caused you distress?
PRIORITIZATION		• Did caregiver's behaviors related to trauma affect the family? • Are these behaviors creating a safety threat? • If nothing changes, will a child living with this caregiver be able to feel safe and secure enough to function in school and in social settings and to develop their own emotional health?
PLANNING	**DESIRED OUTCOMES**	• When caregiver is overwhelmed with feelings of traumatic stress, they always will take action to ensure [child] is safe and secure. • Caregiver will take actions to reduce the impact of traumatic stress on their own life; when it does affect their ability to meet child needs, they will take action to ensure child safety.
	ACTIONS	• Caregiver will work with a therapist to address traumatic stress. • Caregiver will agree to share information on the treatment plan with the worker. • When caregiver is feeling stressed or overwhelmed, they will use techniques to de-stress. (e.g., breathing, self-care, reaching out to safety network)
	RESOURCES	• Therapy such as eye movement desensitization and reprocessing (EMDR), cognitive processing therapy (CPT), and CBT; or other trauma-informed therapy • Support group • Mental health consult

10. COPING SKILLS

INFORMATION GATHERING		• What stresses you out? What do you do when that happens? • What do you do when you are angry? • You have so much on your plate—many people in your situation would not be able to cope. What helps get you through? How do you manage? • On a scale of 0 to 10, where 10 is you feel completely confident that you can handle the level of stress you have now and 0 is that you worry you cannot hang on another minute with all the stress, where are you?
PRIORITIZATION		• Did caregiver's behaviors related to coping skills create a safety threat? • If nothing changes, will a child living with this caregiver be able to feel safe and secure enough to function in school and in social settings and to develop their own emotional health?
PLANNING	**DESIRED OUTCOMES**	• When caregiver is overwhelmed with feelings of stress and finds themself struggling to cope, they will always take action to ensure [child] is safe and secure. • When caregiver is overwhelmed with feelings of stress, they will identify appropriate resources to help them manage that. • When caregiver is overwhelmed with feelings of stress, they will reach out to their network for support to ensure that the child's basic needs are met.
	ACTIONS	• Caregiver will make time every week to practice self-care, such as walking, cooking, knitting, reading, or meditating, based on activities they enjoy. • Caregiver will keep a daily log of their feelings and things they experienced that day, and they will rate their stress level. • Caregiver will arrange for a network member to check in on them three times a week. • Caregiver will help their children know whom they can reach out to when caregiver gets too stressed to cope with caregiving responsibilities. • Caregiver will take time to get established with a therapist or support group in order to help them develop their coping skills and feel less isolated. • Caregivers will make a list of ways in which they are not coping at their best and alternative ways they could act in the future to prevent negative impact on the child.
	RESOURCES	• Safety network • Therapy • Support groups

11. COGNITIVE/DEVELOPMENTAL ABILITIES

INFORMATION GATHERING		Note: Observations are vital for assessing cognitive ability. Listen for comprehension and simple math skills. Observe literacy (which may or may not be related to disability). Collateral sources, especially the caregiver's family, are important. You may ask the caregiver and their family about any issues relating to birth, head injuries, special education, etc. • Tell me what the [doctor/teacher/eligibility worker] asked you to do. Was there anything that you did not understand? • What is your highest level of education? Tell me about your education. • Tell me how you did in school. • Tell me about your daily routine. • Tell me about a time you ever worried about caring for your child.
PRIORITIZATION		• If caregiver fully understood the information previously provided, would the safety threat have happened? • Given caregiver's cognitive level, can safety be created? • If caregiver's cognitive ability is too limited to create safety, can network members fill the gaps to ensure safety? • Given caregiver's cognitive level, can [child] reach their potential? What supplements can be in place for success?
PLANNING	**DESIRED OUTCOMES**	• Everyone in the safety network works together to be sure the caregiver gets the information needed in ways the caregiver can use to keep [child] safe. • Caregiver is able to ask safety network for help if the caregiver is worried they cannot attend to the child's needs properly. • Safety network members check in on the caregiver and child regularly to support caregiver's parenting.
	ACTIONS	• A safety network member goes to all medical appointments to help reinforce the instructions in ways that caregiver can understand and that medical staff endorse as accurate. • A safety network member works with caregiver to create tip sheets with diagrams to show each step of [specific activities that were not being done before]. • While [child] is living [with relative/in foster care], caregiver attends each medical appointment and school meetings. • During visits with [child], caregiver demonstrates new skills they are learning: [feeding child/changing diapers/bathing child]. • Caregiver agrees to share the results of their own psychological or cognitive diagnostic testing as needed.
	RESOURCES	• Cognitive consultation or evaluation • Condition-specific support group

CHILD AREAS

1. EMOTIONAL/BEHAVIORAL HEALTH

INFORMATION GATHERING		• Describe your child for me. Tell me about [child]. • How is your child sleeping, eating, toilet training? Do you have any concerns regarding your child? • When things get frustrating, how does [child] deal with that? • Have you noticed any change in [child]'s behavior? • On a scale from 0 to 10, with 10 being you are very confident in your ability to manage your child's behavior and 0 being you have no confidence, how would you rate things? What would need to happen for you to feel more confident? In terms of willingness to manage your child's behavior, how would you rate yourself? In terms of ability to manage your child's behavior?
PRIORITIZATION		If child is in custody, any identified needs *must* be on the child's family case plan. Consider whether caregiver can be responsible for all or some requirements to address [child]'s emotional or behavioral health. Also include in the family case plan if: • [Child]'s behavior is seen as provoking by the caregiver and created the context for the safety threat. • Responding to [child]'s emotional or behavioral concerns will mean caregiver cannot address other changes needed for safety. And/or • Without *additional* intervention, [child]'s emotional or behavioral health will affect their long-term well-being or impede ability to remain or return home.
PLANNING	**DESIRED OUTCOMES**	• Caregiver responds to [child]'s behaviors in a safe and positive manner. • [Child] experiences a range of feelings in response to things that are happening and is not overwhelmed by [depression/anxiety/anger]. • [Child] responds to life's disappointments and stresses by using strategies to manage behavior in ways that are safe and productive. • When [child] feels [sad/afraid/anxious], they have some coping strategies and more than one safe person to call.
	ACTIONS	• Caregiver ensures that [child] attends every therapy appointment. • Caregiver works with [child] to engage in activities recommended by therapist. • Caregiver works with [child] and therapist to help child develop appropriate communication and coping strategies. • Caregiver will support the child when they demonstrate behaviors that indicate frustration. • Caregiver will model healthy reactions to stressful or frustrating situations or events. • Caregiver works with [child] to create a story about [child]'s feelings that shows more than one way to help when the feelings start to hurt.
	RESOURCES	• Evidence-based therapy • Safety network • Support groups • Child advocacy centers • YMCA or other community recreational centers • Web-based resources • School-based counseling services • Community-based mental health services • Faith-based community resources

2. TRAUMA

INFORMATION GATHERING		• What are some of the things that your child has seen or experienced that made them feel scared or distressed? How did [child] react? Have you noticed any changes in [child] since then? Does [child] talk about it? What is your understanding of this? • *If you have learned that intimate partner violence is present in the situation:* What does [child] say about the things that have happened between the two of you? What does [child] do when that is happening? • How are [child]'s eating, sleeping, and toileting? Have they changed since [event] happened? • Have you ever noticed [child] acting out the same incident while playing, or in drawings? • Have you seen your child suddenly afraid or anxious for no reason? • *Note*: If there is a history of potentially traumatic events, or a history of possible traumatic stress symptoms, consider completing a child trauma screening tool.
PRIORITIZATION		• If child is in care, this domain *must* be on child's plan. Consider whether caregiver can be responsible for some or all of required actions, e.g., transport to therapy, supporting a trauma-informed plan. • Also include this domain in caregiver's plan if any of the following apply. » The circumstances continue to create traumatic experiences for the child. » [Child]'s traumatic stress responses formed some of the context for the safety threat. » Addressing [child]'s traumatic stress will require so much from caregiver that caregiver will be unable to address other changes needed for safety. • Without *additional* intervention, child's traumatic stress will be unaddressed and will likely pose long-term adverse consequences for [child].
PLANNING	**DESIRED OUTCOMES**	• Caregiver does everything necessary so that [child] experiences safety and security and trusts that [the traumatic events] will not continue. • Caregiver supports [child]'s recovery from [trauma] so that [child] has hope and confidence in their future.
	ACTIONS	• Caregiver ensures that [child] attends therapy sessions and participates in the therapy program as recommended. • Caregiver works with therapist to understand possible trauma triggers and works to minimize exposure to triggers. • Caregiver works with therapist to learn ways to calm [child] when [child] is experiencing a traumatic reaction.
	RESOURCES	• Trauma-focused CBT • Trauma systems therapy (TST) • Training for caregiver in responding to trauma triggers

3. CHILD DEVELOPMENT

INFORMATION GATHERING	Note: Observe the child during conversations with the child. Review the cognitive and physical milestones chart in the Policy and Procedures section of the family case plan tool. **Caregiver Questions** • Tell me about the things [child] is doing, like crawling, walking, or turning over. • Tell me about the things [child] is able to do independently. • Is there anything [child] should do for themself that [child] doesn't do? (e.g., clean room, load dishwasher, take a shower, brush teeth) • What things does [child] say a lot? • Does your child go to daycare, Pre-K, or Head Start; or receive Early Intervention services? Has [child] ever received a developmental screening? • Has anyone ever said they are worried about whether [child] is reaching developmental milestones (e.g., walking, talking, toileting)? • Children develop at different times, and differences usually are nothing to worry about. I'm curious—most kids [child's] age have [age-expected behavior]. Has [child] started [age-expected behavior]? • Has your child started puberty? If so, are you experiencing any challenges? How are you managing [identified challenges]? • Tell me a few things [child] does independently. Note: If there is concern about development, consult with professionals and consider obtaining a developmental assessment.
PRIORITIZATION	*Must* be on child's plan if identified as a need and the child is in custody. Consider whether caregiver can participate in services (e.g., transport the child to appointments, participate in care plans, visit the child at school, provide transportation to therapies). Also include in the family case plan if, after any consideration, any of the following exist. • A misunderstanding of [child]'s developmental capabilities contributed to the safety threats. • Stress of coming to terms with the developmental delays contributed to the safety threats. • Lack of stimulation from the caregiver contributed to delays. • Possibility exists that the caregiver will not be able to make other necessary changes for safety, permanency, or well-being. • [Child]'s developmental need will make it difficult for [child] to remain or return home. • Risk exists that the child will not meet their maximum potential if additional interventions are not implemented.

PLANNING	**DESIRED OUTCOMES**	• Caregiver provides [child] with stimulation for growth and development so that child develops to the best of their potential. • Caregiver organizes formal supports to assist [child] with [condition] so that [child] can reach their maximum potential. • Caregiver manages the stress and grief of coming to terms with diagnosed developmental disability and finds new ways to cope.
	ACTIONS	• Caregiver learns specific activities that can be done daily with [child] to help support development (e.g., occupational therapy, physical therapy, exercises recommended by speech therapist), and this becomes part of the family routine. • Caregiver participates in support group with parents of children with [condition]. • Caregiver enrolls [child] in [program] and ensures [child] has transportation to attend the program as recommended by [program]. • Caregiver will ensure [child] has opportunity for social development and interaction.
	RESOURCES	Note: This is not an exhaustive list • Early intervention services • Head Start • Pre-K or daycare • Home visiting programs • Local public library or other community resource • Specialized transportation services (e.g., Medicaid transport)

4. EDUCATION

INFORMATION GATHERING	• Tell me about [child]'s school. (Name of school; public, private, or homeschool; grade; how [child] is doing; how [child] likes it.) How is the curriculum meeting your child's educational needs? • Is your child receiving any additional services at school? (Individualized Education Program [IEP], resource classes, 504 services) • If your child is receiving special education services, when was the last planning and/or evaluating meeting? • What does [child] like best about school? Least? • What does [child] do well in school? Where does [child] struggle? • What is homework like for [child]? Who helps [child] with homework? • Is your child performing at grade level? • Is your child receiving tutoring? • On a scale of 0 to 10, with 10 being highly satisfied and 0 being unsatisfied, how would you rate your satisfaction regarding communication with the school? Why did you select that rating, and what would it take to improve communication? • Does your child attend school regularly? If no, why not? • Has your child ever had to change schools? Can we make a timeline? What events led to your child changing schools? What was the impact on your child, socially and academically, of changing schools? • If your child had to change schools, what would that mean for your child?
PRIORITIZATION	For children in care, the child's plan of service *must* address education. In particular, if the child is leaving the school they attended at the time of removal, explain why it was not in the child's best interest to stay. If the child misses any school days, explain why. Consider contacting the DCFS Educational Specialist for assistance. • Consider whether caregiver can remain responsible for some or all of [child]'s education plan while [child] is in care. Items in plan may include transportation, participation in teacher conferences, participation in IEP meetings, and possibly assisting with homework or attending extracurricular activities. • Consider whether the parent can remain responsible for keeping [child] in school. Also include in the family case plan if any of the following apply. • Issues related to education contributed to context for safety threat. • Caregiver's responsibilities for [child]'s education will make it difficult for caregiver to make other changes needed for safety. • Without additional intervention, [child]'s educational success will be jeopardized.

PLANNING	**DESIRED OUTCOMES**	• Caregiver supports [child]'s educational needs to the extent that [child] is engaged in education and working to the best of their ability. • [Child] is engaged in education and is working to the best of their ability.
	ACTIONS	• Caregiver advocates for new or modified education plan for [child]. • Caregiver meets regularly with school staff and partners with school staff to create the best learning environment for [child]. • Caregiver makes sure [child] is awake every morning in plenty of time to get to school on time. The caregiver will access the safety network for assistance if necessary. • Caregiver makes sure [child] has access to appropriate clothing and a healthy breakfast. • Caregiver spends [amount of time and frequency] supporting child to complete homework and/or read a book together. • Caregiver supports [child]'s interests and extracurricular activities.
	RESOURCES	• Onsite school resources • School district and staff (e.g., resource officer, counselor, teachers) • School-based mental health therapy • DCFS Educational Specialist • Regional educational specialist • School district foster care liaison • Disability rights agency • Mentoring • Early Intervention services • Surrogate parent

5. SOCIAL RELATIONSHIPS

<table>
<tr><td colspan="2">INFORMATION GATHERING</td><td>Caregiver Questions

• How does [child] get along with peers? Who are their friends? What do they do together?
• How does [child] get along with adults? Tell me about your child's relationships with other adults. Do you have any worries about any of these relationships?
• Does your child have a social media account? If so, how many friends do they have? How much time does your child spend on social media?

Child Questions
Note: Circles of Safety and Support can be particularly useful for this item.

• Tell me about your friends. What do you like to do with them?
• What do you like to do after school and on the weekend?
• Do you get along with others your age?
• Do you feel comfortable sharing honestly about yourself? Tell me more about that.
• Do you find to it easy to make and keep friends?
• Who are your favorite grown-ups? What do you enjoy about those people?
• When you are with [peers/adults], on a scale of 0 to 10, where 10 is you love spending time with other people and feel most happy when you are with them and 0 is where you would rather be alone, where are you?
• When you feel sad or upset, who do you ask for help?
• Are you on social media such as Facebook, Twitter, Instagram, etc.? Tell me more about that.</td></tr>
<tr><td colspan="2">PRIORITIZATION</td><td>If child is in custody, any identified needs must be on the child family case plan. Also include in family case plan if:

• [Child's] isolation makes them extremely vulnerable to the safety threat.
• Conflicts over [child]'s social relationships form all or part of the context for the safety threat. For example: Unless [child] has greater success forming peer or adult relationships, [child] is likely to experience increasing social isolation and will form increasingly negative self-image.</td></tr>
<tr><td rowspan="3">PLANNING</td><td>DESIRED OUTCOMES</td><td>[Child] is comfortable in relationships with peers and adults and has healthy relationships that form a safety network for [child].</td></tr>
<tr><td>ACTIONS</td><td>• Caregiver provides opportunities for [child] to gradually increase social connections.
• Caregiver helps [child] identify safe and supportive peer and adult relationships.</td></tr>
<tr><td>RESOURCES</td><td>• Social skills groups
• Group and community activities
• Faith-based activities
• Boy and Girl Scouts
• Big Brothers Big Sisters programs
• YMCA
• Family counseling</td></tr>
</table>

6. PHYSICAL HEALTH

INFORMATION GATHERING	**Caregiver Questions** • How is your child's health? • What type of health care or medical interventions are valued in your family? • Is [child] seeing a doctor or medical professional? If so, what types of medical professionals? • Do you experience any barriers to or hesitancy related to accessing effective care? • Does your family have health insurance? If not, are you interested in information about health insurance options? • When was your child's last doctor visit? What did the doctor say? • If [child] has any special health care needs, what do you need to do every day to help [child] live with [condition]? • Did you have to get special training to know how to do that? • Does [child] require some equipment or supplies for [condition]? • On a scale of 0 to 10, where 10 is that you are confident your child is healthy, active, and growing strong and 0 is that you are very worried about your child's health all the time, where are you? • Is your child on any medicine? If so, what and how often? • Does anything ever get in the way of meeting your child's medical needs (e.g., medication as prescribed, medical equipment, medical care)? • Has your child ever been recommended for any speech, occupational, or physical therapy services? • Does [child] receive any speech, occupational, or physical therapy? If so, who does your child see and for what? How often? • Do you immunize your child? If so, is your child current? If not, tell me more about that. • Tell me what your child eats. • How frequently do you take your child to the dentist? What did the dentist say last time? • Do you ever worry you won't be able to meet your child's health needs? If so, why?
PRIORITIZATION	*Must* be on child's plan of service if identified as a need and the child is in custody. Consider whether caregiver can remain responsible for any or all aspects of child's physical health. Include in family case plan: • [Child]'s physical health makes them more vulnerable to the safety threat. • [Child]'s physical health will make it difficult for [child] to remain or return home. • Caregiver will be unable to focus on other necessary changes because of the demands of [child]'s physical health issues.

PLANNING	**DESIRED OUTCOMES**	Caregiver ensures [child] is as healthy and active as possible.
	ACTIONS	• Caregiver will work with medical team to learn everything a caregiver needs to know about [condition] so the caregiver can care for [child]. • Caregiver will work with safety network to create a plan to be sure that all of the child's medical needs are being met. • Caregiver will work with placement caregiver to schedule medical visits and will participate in the child's medical visits. Caregiver is responsible for informing placement caregiver of any requirements for care.
	RESOURCES	• Safety network • Medicaid or other insurance • Support groups for parents of children with [condition] • Medical transportation service • Medical education • In-home nursing (if needed) • Physical health and diet education

7. ALCOHOL/DRUGS

INFORMATION GATHERING	**Caregiver Questions** • What do you identify as drugs? • What terms do you and your family use to describe drugs and alcohol? • What conversations have you had with your children on the subject of alcohol, drug use, and smoking cigarettes or vaping? • Do you have any reason to believe that [child] is using or has friends who use substances? If yes, tell me more about that. • When you were growing up, how did your family handle the subject of alcohol and drugs? Is there any history in your family of substance misuse? **Child Questions** • What do you identify as drugs? • What terms do you and your family use to describe drugs and alcohol? • Have you ever used alcohol or drugs? When was the last time you used? How much did you use? • Have you heard about kids at school or in the neighborhood who try alcohol or drugs? How do you feel about that? Have you ever wanted to use alcohol or drugs? If yes, tell me more about that. • Have you ever seen your caregiver use drugs or alcohol? • Has your substance use negatively affected your home life or school or relationships? [Follow up with a scaling question.] • Is someone in your life worried about your substance use? If so, tell me more about that.
PRIORITIZATION	If child is in custody, any identified needs *must* be on the child's family case plan. Also include in family case plan if any of the following apply. • [Child]'s use creates a safety threat for [child]. • [Child]'s substance use plays a role in the safety threat in the home. • Addressing [child]'s use will require so much of caregiver's focus and resources that caregiver will be unable to make other changes necessary for safety. • Without *additional* intervention, [child] is likely to become involved in the justice system, develop a substance misuse problem, or experience other short- or long-term adverse consequences.

PLANNING	**DESIRED OUTCOMES**	[Child] remains alcohol and drug free.
	ACTIONS	• Caregiver arranges house so that [child] does not have access to alcohol or drugs. • Caregiver supports [child] to develop relationships and activities that do not include alcohol or drugs. • Caregiver and [child] develop and maintain a relapse plan. Caregiver helps [child] identify support systems that can assist when [child] wants to use. • [Child] asks for support when thinking about using. • Caregiver understands the importance of modeling the use of legal substances in moderation. • Caregiver understands their role in affecting [child]'s relationship with substances. • Caregiver will have [child] complete substance misuse treatment and follow recommendations.
	RESOURCES	• Evidence-based treatment • Written resource material, on paper or online • Community support groups such as Al-Anon, Alateen, faith-based programs, inpatient and outpatient programs • Family in need of services

8. DELINQUENT BEHAVIOR

<table>
<tr><td colspan="2">INFORMATION GATHERING</td><td>Caregiver Questions

• Has your child ever admitted to breaking the law? Has your child ever been ticketed, arrested, detained, or placed on probation? If so, for what?
• Does your child have any pending legal actions or scheduled appointments (e.g., probation appointments, community service, court hearings)? If so, do you have any paperwork on it?

Child Questions

• Have you ever broken the law? If so, tell me more about that.
• Have you ever gotten in trouble for [fighting/bullying/skipping class]? How often has it happened?
• What helps to keep you from getting into trouble? What helps you make good choices?</td></tr>
<tr><td colspan="2">PRIORITIZATION</td><td>Include in family case plan if:

• Reasons [child] is involved in delinquent behavior, or the mere fact of involvement in delinquent behavior, form all or part of the context for the safety threat.
• Caregiver will be so heavily involved with energy, time, or resources in dealing with results and consequences of the delinquent behavior that they will be unable to address other changes needed for safety.
• Without additional intervention, [child] is likely to follow a path of chronic or increasing delinquent behavior.

If a child is in custody, any identified needs must be on the child's family case plan regardless of whether the above is true.</td></tr>
<tr><td rowspan="3">PLANNING</td><td>DESIRED OUTCOMES</td><td>• Caregiver helps [child] develop ways to make decisions and take actions that do not expose [child] to further delinquent behavior involvement.
• [Child] is no longer participating in delinquent behavior. (This is not a requirement for the child to return home if in care.)</td></tr>
<tr><td>ACTIONS</td><td>• Caregiver helps [child] learn ways to:
» Manage behavior even when very angry;
» Resist pressure from others who want to break the law;
» Use resources to work toward desired goals; and
» Find constructive, positive outlets to occupy free time (e.g., sports, job, volunteering, clubs).
• Caregiver agrees to provide any paperwork and/or follow through with pending legal action.
• [Child] will work on demonstrating healthy coping skills.
• [Child] will participate in all referred services.
• [Child] will work on managing their behavior when they are angry.</td></tr>
<tr><td>RESOURCES</td><td>• CBT
• Positive activities such as sports, music, theater, art, recreation
• Community resources such as Big Brothers Big Sisters programs, Communities In Schools, Intensive In-Home Services (specifically Family Centered Treatment or Intercept)</td></tr>
</table>

9. FAMILY OF ORIGIN RELATIONSHIPS

<table>
<tr><td colspan="2">INFORMATION GATHERING</td><td>

How does [child] get along with others in the family? With whom is the child closest? Does the child have a difficult relationship with anyone in the family?
How does [child] spend their time when at home?

Child Questions
Note: Completing the Three Houses, Safety House, or Circles of Safety and Support can be particularly helpful for this item.

On a scale of 0 to 10, where 10 is that you know everyone in your family loves you and you get along with them better than you could have imagined possible and 0 is the opposite—you feel like an outsider in your family—where are you?
Tell me about what you like to do with [caregiver/sibling].
When you feel sad or upset, who do you talk to?
If you could change something about your home, what would that be?

</td></tr>
<tr><td colspan="2">PRIORITIZATION</td><td>

Do conflicts in family relationships form all or part of the context for the safety threat?
Do conflicts consume so much time, energy, and resources that caregiver cannot address any other changes needed?
If nothing changes, is it likely that [child] will have difficulty forming healthy relationships or experience long-term emotional harm because of family conflict?

</td></tr>
<tr><td rowspan="3">PLANNING</td><td>DESIRED OUTCOMES</td><td>[Child] feels loved and protected by everyone in the family and has positive experiences within the family.</td></tr>
<tr><td>ACTIONS</td><td>

Caregiver and [child] spend at least an hour a week together doing an activity they both enjoy.
Caregiver organizes at least two family activities every month.
Caregiver and [child] participate in family counseling or any other group that will provide mutual support for both child and caregiver.
Family works out shared agreements for how they will work as a family.

</td></tr>
<tr><td>RESOURCES</td><td>

Family therapy
Activities in the community, church, YMCA
Family activities and extracurricular activities

</td></tr>
</table>

10. RELATIONSHIP WITH SUBSTITUTE CARE PROVIDER (IF CHILD IS IN CARE)

INFORMATION GATHERING	**Substitute Care Provider (SCP) Questions** Please interview the SCP outside the presence of the child. • Describe [child] for me. Tell me about [child]. • What is it like having [child] in your care? What works well? What worries you? • Tell me about how the child has maintained connections with their family. How have you supported that? • Have you had a worry that you were able to resolve? Tell me more about that. • Who do you call for support when you are worried? What types of support are available to you as a placement caregiver? • Do you have contact with the child's family? If so, tell me about your interactions with the family. • How is the child getting along with other people in the placement (e.g., other children, resource parents, siblings, adults)? • On a scale of 0 to 10, with 0 being the child does not fit in and 10 being the child is a natural fit, how well does the child fit in the placement? **Child Questions** Please interview the child outside the presence of the SCP. Note: Completing the Three Houses, Safety House, or Circles of Safety and Support can be particularly helpful in relation to this item. • Do you feel safe and secure in your placement? • On a scale of 0 to 10, where 10 is that you know everyone in the placement setting cares about you and you get along with them better than you could have imagined possible and 0 is the opposite—you feel like an outsider in this family—where are you? • When you feel sad or upset, with whom do you talk? Do you feel like you can go to your current caregiver when you are upset? If not, why? • Is there anything you do not like or that worries you about living here? Have you had a worry that you were able to resolve? Tell me more about that. • How would you describe a typical day at your current home? How do you think your current caregiver feels about your [habits, activities, differences, values]? What makes you think that? • Would you like to tell me anything else about your relationship with your placement household? Is there anything you would like to ask me? • What's your favorite thing to eat? What does mealtime look like? • What happens when you get in trouble? Who disciplines you? What are the rules of the house?
PRIORITIZATION	If child is in custody, any identified needs *must* be on the child's family case plan.

PLANNING	**DESIRED OUTCOMES**	[Child] feels accepted and supported by placement family.
	ACTIONS	• Placement family meeting to address concerns. • Placement family and [child] work out agreements for living together. • Placement family learns about [child]'s story, particularly any trauma history, and how to help [child] when trauma triggers lead to troubling behaviors. • Placement family learns about [child]'s [self-image, community connections, individual characteristics] and identifies ways to support [child].
	RESOURCES	• Trauma-informed parenting training • Written materials, on paper or online • Community organizations • Faith-based organizations or houses of worship • Local mental health authority • Child-placing agency • Respite care (formal or informal)

11. TRANSITIONAL YOUTH SERVICES (IF AGE 14 OR OLDER)

INFORMATION GATHERING	**Caregiver Questions** • If [youth] was given permission to live independently today, how would they do? • On a scale of 0 to 10, where 10 is you are confident they would be safe and could navigate all adult responsibilities like handling money, maintaining a place to live, eating healthy, getting to school or work, etc.; and 0 is where living alone would be an instant disaster, where are you on the scale? What made you choose that number, and what would it take to move it up by 1? • Was there a time when you were sure [youth] would make an immature decision, but they surprised you and made a good choice? **Youth Questions** • Let's talk about things adults have to do and get a sense of how much you already may know. » Ask about budgeting, money, checkbook, credit, paying bills. » Ask about finding a place to live and what it takes to maintain it. » Ask about deciding what to eat and having enough money for food. » Ask how they plan to support themself. » Ask: If you were out on your own and something happened and you needed help, who would you call? » Ask: If you needed someone to cosign for you on a loan, who would you call for help? » Ask: On a scale of 0 to 10, where 10 is having all the people you need to help you out when you are in trouble and 0 is where absolutely no one would help you out, where are you? • On a scale of 0 to 10, where 10 is you are confident you would be safe and could navigate all adult responsibilities like handling money, maintaining a place to live, eating healthy, and getting to school or work; and 0 is where living alone would be an instant disaster, where are you on the scale? What made you choose that number, and what would it take to move it up by 1?
PRIORITIZATION	If youth is in custody, any identified needs *must* be on the youth's family case plan. Also include in family case plan if caregiver can be a valuable resource for preparing youth.

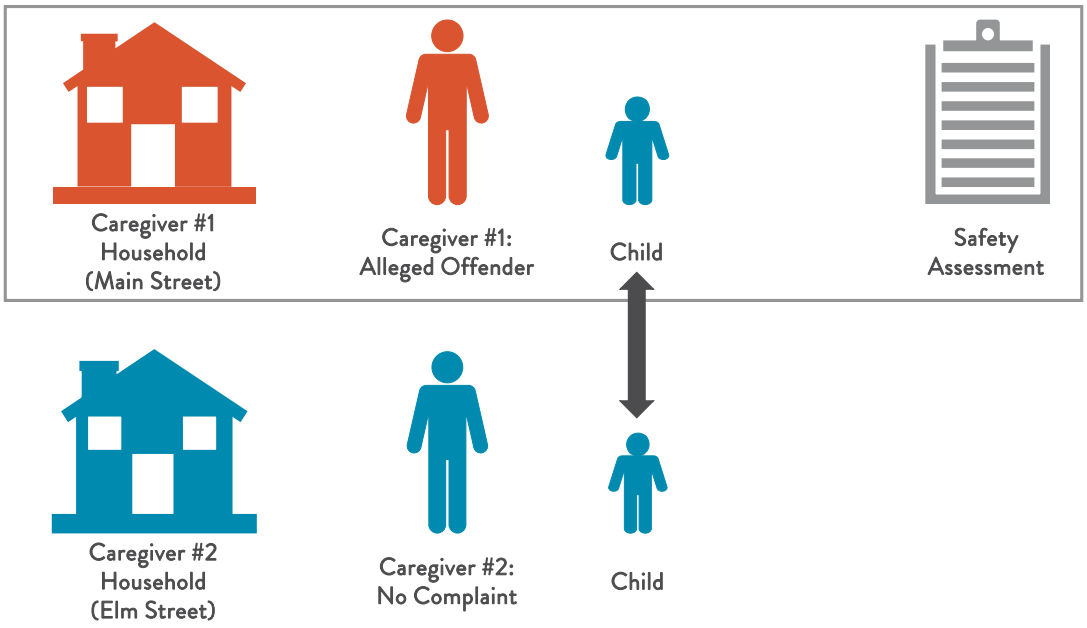
PLANNING	**DESIRED OUTCOMES**	[Youth] will reach adulthood prepared to live independently.
	ACTIONS	• Youth and safety network create a transition plan. • Youth identifies adults to support them through the transition to independence. • Youth learns to: » Handle money; » Secure and maintain a residence; » Move around as needed (driving, public transportation); and » Purchase, prepare, and store nutritious food. • Youth acquires employment skills by: » Part-time work; and/or » Job skills training. • Youth applies for community college, college, or university.
	RESOURCES	• Safety network • Transitional Living Services • Transitional Living Programs • School guidance counselor • Youth leadership councils, youth advocacy groups • Arkansas Rehabilitation Services • Division of Aging, Adult, and Behavioral Health Services transition program

APPENDIX C: HOUSEHOLDS

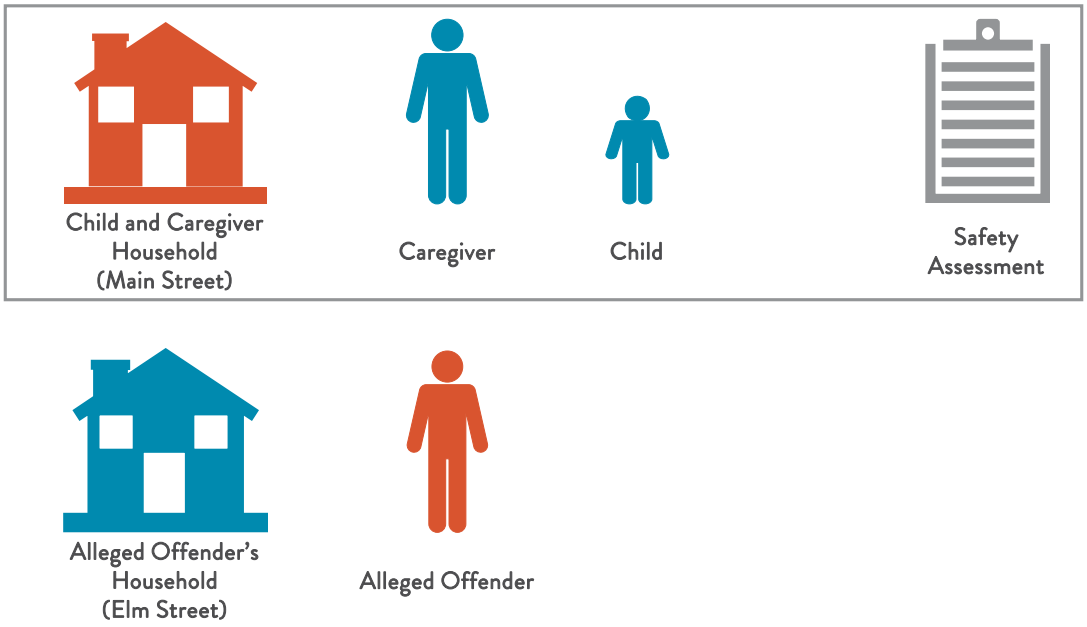
This appendix provides additional examples for how to determine which household to apply SDM assessments to during an investigation or DR assessment.

WHICH HOUSEHOLD(S): COMMON SCENARIOS

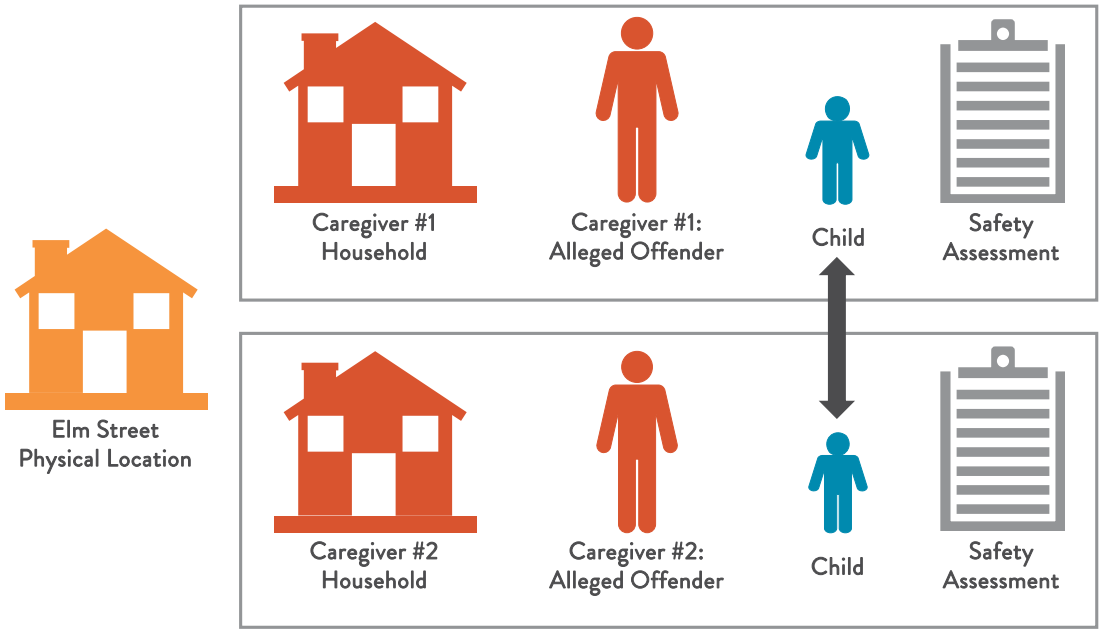
If the alleged offender is part of the child's household, assess that household.



If the alleged offender is not a member of the child's household, do *not* complete a safety assessment for the alleged offender's household. In this situation, instead complete a safety assessment for the child's caregiver's household, but only if there is also an allegation of failure to protect.



If the abuse or neglect involved more than one household at the same address, assess each household where the alleged abuse or neglect occurred.



FOR ALL HOUSEHOLD CONFIGURATIONS

Do not complete an SDM safety assessment unless a new allegation of maltreatment is made on a non-custodial parent's household.

- If a reportable condition is determined during the home study, file a report as policy indicates and complete new SDM assessments for this household.
- In cases where the household is unsafe AND the other caregiver requests reunification services, you should also complete safety, risk, and reunification assessments, following the timelines provided for when to complete each one on each household. Child will be placed in foster or kinship care until it is safe to return to the caregiver who successfully completes services and the behavior changes.
- All relevant SDM assessments should continue with the original custodial parent regardless of the original non-custodial parent's current custodial status.

Third-party reports: When the reported harm concerns harm to a child by a non-household member, only complete an SDM safety assessment for the household of the caregiver where the child resides if there is also an allegation on that caregiver.

- Only complete an SDM safety assessment for the household of the caregiver where the child resides if there is also an allegation on that caregiver. If a safety threat is found, a new investigation should be opened on that household and an SDM risk assessment is required. If there is no safety threat, no further SDM assessments are required on that household.
- If other children who may be victims are living in the household with the third-party perpetrator, an investigation with the allegation concerning those children should be added, and an SDM safety and risk assessment should be done on that household.